CONTENTS

For July, 1937

Just in Passing—

BEFORE the year is out every hospital administrator will probably be tired of the joke about hospital labor pains. But the situation continues. In Chicago, for example, last month the Hospital Employees Union, an American Federation of Labor organization, voted to withdraw from the A. F. of L. and to join the Committee for Industrial Organization. The new name of the union is the United Hospital Workers of Chicago. This month we present two articles of special interest to administrators facing the unionization of their employees. One, by Doctor Bluestone, continues the valuable discussion which he began in the April issue under the title, "A Labor Program for Hospitals." The other is a statement of the rights and obligations of hospital employees as formulated by a committee of the Chicago Hospital Council and the Chicago Hospital Association. Because this statement was intended for distribution to employees, it is couched in general terms. Another more definite statement for trustees and administrators also has been prepared by this joint committee. It advocates a wage scale comparable to industry, a forty-eight-hour week, reasonable notice of discharge or a cash payment in lieu of notice, and good meals and housing conditions.

AN EMERGING profession, that of medical technologist, is asking for your recognition and assistance. In 1933 the American Society of Medical Technicians was formed. Membership is restricted to registered technicians. Next month Frieda Claussen of Charles T. Miller Hospital, St. Paul, Minn., will outline the objectives, aspirations and ethics of this group.

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CONTENTS

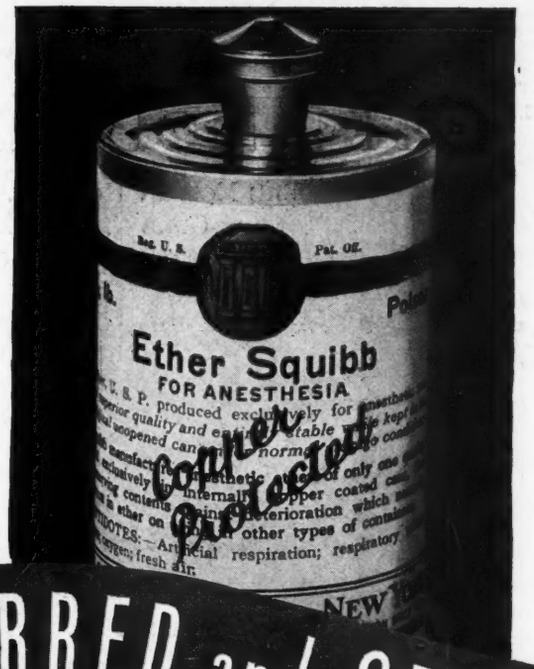
THE Works Progress Administration has been aiding in the construction and rebuilding of government owned or supported hospitals in all parts of the country. Next month Howard Wharton will begin an account of stewardship of the public's money. The first article will deal with work on children's institutions. It is liberally illustrated with plans and photographs. Subsequent articles will cover tuberculosis and mental institutions.

THIS month Doctor Doane presents the work and responsibilities of the surgical supervising nurse. This also is the first of a series of articles. Next month he will analyze the work of the medical supervising nurse, and the following month will list the equipment that she needs to carry out her duties fully.

DR. HARLEY A. HAYNES, director, University of Michigan Hospitals, takes obvious pleasure in guiding hospital visitors to the top floor of his great institution. And well he may, for here is one of the most interesting and constructive features of the hospital—the occupational therapy department. Next month Mrs. Kasabach, the occupational therapist, will describe this department.

DOES civil service mean mediocre service? Is it possible to achieve high standards in the selection of employees of government institutions and at the same time give them the protection against spoils politics that are envisaged by the civil service laws? Irene Grant of the U. S. Veterans Administration believes it is and she has had extensive experience in the selection of social service workers. She suggests specific methods.

OF COURSE you are going to Atlantic City in September for the meeting of the A. H. A. Plan your trip so as to make it contribute the most to your own education and enjoyment. Why not visit the most important hospitals that you can? Next month we bring you help in planning such an itinerary.



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SQUIBB ETHER

A NEW feature in this issue will be found on page 56. We have called it "With the Roving Reporter." In it you will find various bits about hospitals that we think are of interest. We hope you, too, will find them so. If you know of something that would interest the "roving reporter," don't hesitate to let the Editors know. We make no guarantee of what the reporter will discover. He has a carte blanche.

THE long awaited agreement between the hospital and the radiologists was finally consummated last month. While the agreement stresses particularly the quality and professional standing of the radiologic departments, the most controversial aspects deal with economics. In brief, the agreement approves the compensation of the radiologist on a salary, a commission or a "privilege rental" (i.e. concession) basis, "but in no instance should either the hospital or the radiologist exploit the other or the patient." The separation of "technical" and "professional" x-ray service is condemned. This agreement has been approved by all the radiological societies and by the Council on Medical Education and Hospitals of the A.M.A. Copies may be obtained from MacCahal, secretary, Radiological Inter-Society Committee, 2561 North Clark Street, Chicago. Now if the committees can just define what constitutes "exploitation," there should be perpetual peace on the radiologic front!

FLASHES FROM THIS ISSUE:

"Labor in its finest sense had always been credited with philanthropic motives, so far as the hospital was concerned, and it seemed a foregone conclusion that the hospital worker would accept this view of his activities." *Page 48.*

"Our field trips give the student nurses some mutual interests outside of their profession which they can discuss, as too frequently nursing is the only subject which the students have in common." *Page 61.*

"The woman's board, also, has made donations of a housewifely nature to provide articles which would otherwise have to be supplied through the general budget of the men's board. For more than twenty years two hospital dining rooms have been kept completely equipped with silver through collections of soap wrappers." *Page 78.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.
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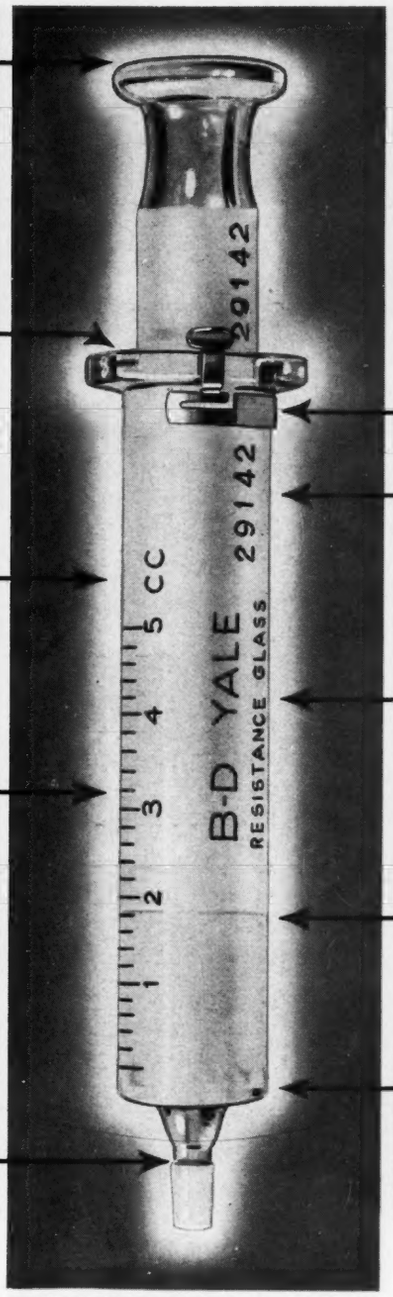

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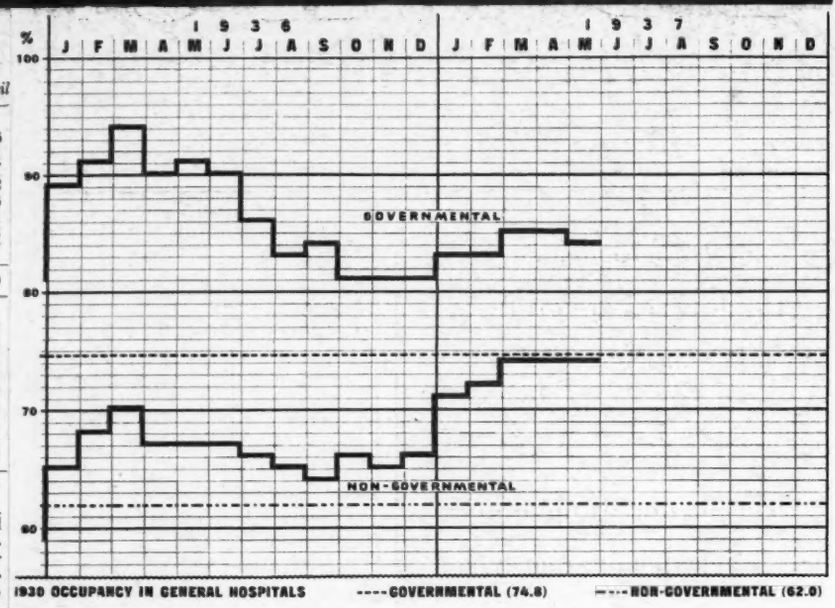
HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data, on Reporting Hospitals[1] Hosp	Beds[2]	1937 May	1937 April	1936 May	1936 April
Government						
New York City	17	11,328	99	100	100	96
New Jersey	5	2,122	89*	89	84	81
Washington, D. C.	2	1,596	70*	70*	63	67
N. and S. Carolina	13	1,429	72*	72	73	72
New Orleans	2	2,466	97*	98	164	146
San Francisco	3	2,255	89	92	81	81
St. Paul	1	559	73	77	80	83
Chicago	1	3,330	87*	87	85	87
Total[4]	44	25,376	84*	85*	91	90
Nongovernment						
New York City[3]	68	15,194	78*	78*	76	75
New Jersey	53	9,772	72*	72	66	66
Washington, D. C.	9	1,793	77*	77*	71	71
N. and S. Carolina	103	6,432	70*	70	65	65
New Orleans	7	1,146	68*	68	59	58
San Francisco	16	3,129	77	79	71	72
St. Paul	7	824	77	77	61	61
Chicago	20	3,582	68	67	64	63
Cleveland	9	1,343	82	75	74	73
Total[4]	292	43,215	74*	74*	67	67

[1]Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. [2]Including bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January, 1933, to October, 1936, are given on page 800 of the Fifteenth Hospital Yearbook.



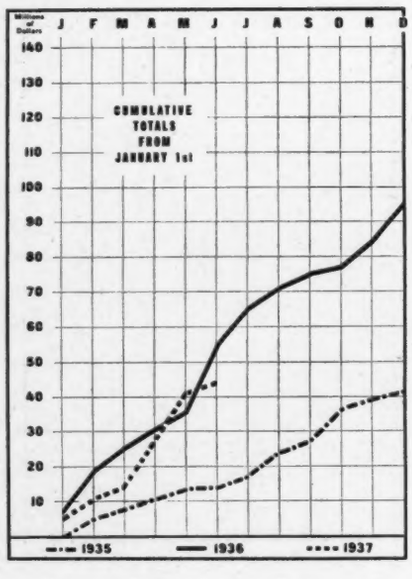
Record Occupancy Is Maintained for Third Month

The postdepression record high occupancy of 74 per cent reached by the voluntary hospitals in March and April was maintained in May according to preliminary and, as yet, incomplete figures. Good business for nongovernment hospitals is apparently spread quite generally throughout the whole country, only New Orleans and Chicago reporting figures below 70 per cent in the last three months. Last year the May occupancy in all reporting voluntary hospitals was 67 per cent.

A further relief in the load on government general hospitals was also recorded in May. Curiously enough, the May occupancy in government hospitals this year was seven points below that of last year while in the voluntary institutions the increase was also seven points. This concurrence is a fortuitous but striking evidence that the load is becoming more normally equalized between the two groups.

New building projects were not quite so numerous or so large during June as they were in May. Thirty-two new projects were reported with total costs of $3,464,640. Ten new hospitals are planned, all of them small, and costing in the aggregate $927,000. There were 19 additions planned, of which 17 were to cost $2,370,000, and three alterations costing $167,640.

HOSPITAL CONSTRUCTION



General wholesale prices as reflected in the index of the *New York Journal of Commerce* dropped somewhat from May 24 to June 21, the index moving from 91.8 to 89.9. Most spectacular was the fall in grain prices, from 117.7 to 103.8 in the period. Food costs consequently went down from 83.3 to 81.6. Textiles and building materials also dropped, the former going from 77.2 to 74.2 while the latter fell from 109.5 to 106.4. (All indexes based on 1927-29 as 100.) The price index for drugs and fine chemicals of the *Oil, Paint and Drug Reporter* remained unchanged at 181.5 for the month.

A substantial rise in living costs of wage earners was noted in May, according to the regular survey of the National Industrial Conference Board. In May of this year, the cost of living was 0.6 per cent higher than in April, 6.0 per cent higher than in May, 1936, and 23.8 per cent higher than in the spring of 1933, the low point during the depression, the board reported. However, the figure was still 10.3 per cent below the level of May, 1929.

Food prices for wage earners rose 1.1 per cent from April to May, clothing prices increased 0.7 per cent, rents went up 1.1 per cent, sundries went up 0.2 per cent, while coal declined seasonally by 2.3 per cent.

The Editor Talks It Over

• There is no piece of equipment in the hospital which suffers greater ups and downs in its existence than does the hospital elevator. Not only physically is this true but the very appearance of this hospital ward, movable though it may be, bespeaks the tidiness, the zest of hospital administration more perhaps than any other. Ill-kept signs on the elevator wall, a general lack of cleanliness and a slovenly, poorly uniformed operator are in strong contrast to the spick-and-span elevator cage in the office building with the sleek businesslike young thing who serves as its skipper. Why hospitals are content with uncouthness in elevators is difficult to understand. Indeed, in some cases, inspection of the elevator pit and the top of the cage might discover a place where a profitable crop of potatoes might be grown, so thick is the accumulation there of dust and grease.

• The foot of the master is the best fertilizer, runs the old saying. This means that supervision makes the work go forward, preventing sloth, correcting inaccuracies and controlling waste of effort and supplies. The closer the executive is to his job, the greater must be the detail of his supervision. He must direct but not nag; he must instruct but not perform the work of others; above all, he must inspire workers in the job and weld them into a cohesive, coordinated team. This is the place where the highest quality of leadership comes in and without it the effort will be bungled. Organization, deputization and supervision—on these three hangs all the law of putting the job over.

• In 1746 one Doctor Godfrey remarked that the proper ways of feeding one's body were little known, and that the chief aim of human beings seemed to be to gratify the itch of the palate. Doctor Godfrey concluded that he was convinced that bodies were designed to last for ninety years and that when we fell short of this period we did so because we erred in the quality or quantity of our ailment.

No doubt there is much truth in the sage remarks of this old physician. "Pruritus palati" is certainly a universal and often fatal disease. Dietitians, however, sometimes wish that hospital patients were more usually affected with an itch of the palate so that they would more thoroughly enjoy the results of their chemical manipulations of raw food by the use of heat. How efficient is the addition of a sprig of parsley or a dash of paprika on a patient's tray in causing the stomach to purr instead of scratch and meow! Epigastric discomfort is sure to produce disheveled tempers and unreasoning personalities.

• At a recent dinner given to a distinguished clinician in honor of his seventieth birthday, the guest, in explaining his plan for avoiding the slowing-up processes of old age, said he believed an eternal curiosity as to the nature of things just around the corner had kept him young. Curiosity may be a petty trait or it may represent an everlasting inquisitiveness as to what is just ahead scientifically, economically and historically. The scientist, the physician, the hospital administrator who does not maintain his sense of curiosity is likely to lose his joy of living.

• "Dr. R. resigned as superintendent of Hospital X to take effect May 1. He is succeeded by Dr. B." Thus reads the cold statement of the termination of office of one executive and the assumption of his duties by another. Behind such news items often lies the story of intrigue, of political chicanery, of oppression by a board or a community of the most cruel sort.

Not always, however, is this the case since Dr. R. after long years of service may have been pensioned by an appreciative board and Dr. B., his assistant, whom he has trained, assumes office with the blessings of his preceptor. Promising young men and women, however, will not be found in great numbers to enter hospital administration as a life work until this profession can be more standardized and its tenure of office more certain.

In Pennsylvania the teachers' tenure bill guarantees continuance in office unless convicted of some unmoral or unprofessional act. Throughout the field institutional superintendents have no such protection. They come and go at the whim of a board, often not judicial in its approach to problems and frequently unreasonably personal.

• An old Arabian proverb stated that a pupil without practical training, who seeks competence by merely hearing lectures and by the repetition of discourses, is like an ass with a burden of sandalwood, for he knows its weight but not its value. This statement might well apply to the profession of hospital administration. One may not learn to conduct an institution well by reading or by hearing the most profound lectures. One must walk the wards, know the functioning of the hospital both day and night. One must feel the sting of failure and the joy of success. Faith without works is as fatal in hospital administration as it is in less concrete matters.

• When one looks back but a decade or two one is startled to remember the disfavor which short-haired nurses created in the minds of their austere superiors. It is difficult to restrain at least a reminiscent smile when one recalls the threats of expulsion which were made should a pupil nurse dare to bring about any abbreviations of her hair. Smoking on the part of nurses then was anathema as it should be more often now. Jewelry on duty, and finger nails resembling a sunset, were frowned upon. Woolen hose, long tresses, a demure countenance and the absence of cosmetics were in strong contrast to that debonair young thing who flits about hospital corridors of today. A change for the better? Perhaps—

Looking Forward

Courage of an Ostrich

IT IS said that when danger menaces, the ostrich is convinced of its safety if it can thrust its head beneath the sand and thus no longer see what threatens.

The hospital often employs just such tactics. It convinces itself that it is safe to neglect to take liability and property insurance on its ambulance because it is difficult, if not impossible, to recover from a charitable institution. Often no attention is paid to the need, the fairness of buying malpractice insurance for its specialty department heads or other types of personal liability protection which individuals or corporations normally carry.

To take refuge behind a legal technicality is neither wise nor ethical. The hospital should protect itself against prosecution by the unscrupulous in the same measure as would any institution of a less charitable nature.

Section 110 New York Penal Law

"A PERSON who willfully or maliciously . . . breaks a contract of service of hiring, knowing or having reasonable cause to believe that a probable consequence of his so doing will be to endanger human life . . . is guilty of a misdemeanor."

This is an unequivocal and wholly definite statement which New York law makers laid down to govern those who desert places of trust to further their own selfish interests. It was under this statute that recently almost a score of striking hospital workers were tried and convicted when they left the post of duty at the command of a labor organizer. But legal provisions with punitive clauses are poor substitutes for that rare quality called Conscience.

The brave boast of twelve months ago, that while most other institutions have felt the devastating effect of labor trouble the hospital has escaped and will escape, no longer can be made. Even a few graduate nurses have listened to the call of the siren and allowed their names to be placed on the rolls of organized labor. The physician if he has been approached has turned a deaf ear to such suggestions.

While the hospital world must hang its head in shame because of the acts of those who have so ruthlessly defied its traditions it must applaud the action of the judges who punish men and women who only regard human life in terms of their own.

How to Raise Salaries

DURING the period of the late lamented depression most hospitals found it necessary to scale downward their salary lists drastically. Often this was done fairly on a bracket basis, each individual receiving a percentage cut based on a salary or duty classification.

Greatly to the credit of hospital workers in general this reduction in income, difficult as it was at the time, was accepted without a murmur. Some institutions have already replaced the reduction then made. Others are contemplating doing so in the near future. A few apparently feel that it is neither fair nor necessary to return to former wage scales.

To replace cuts on an individual basis is disastrous. The very unrest which such increases are aimed to avoid will be multiplied tenfold by such a program. It may not seem feasible to replace all cuts with one stroke of the pen. This may have to be done piecemeal. But, omitting consideration of the time element involved, the same system of instituting increases should be followed as was employed in making effective reductions.

Were one to consider individuals, the abstract element of faithfulness and worth to the hospital enters and this is not subject to proof. Hence jealousy, suspicion and lowered morale will surely follow this type of wage increase. It is

better for those in the lower brackets to feel that they have received fair play at the hands of the board than to have the suspicion that favoritism has been shown to those in higher authority.

It appears that increases in wage and salary schedules must, almost inevitably, be given. The methods by which this is brought about are of paramount importance to institutional morale.

"No Money Is Appropriated"

RECENTLY there met in the nation's capital a great group of persons interested in many angles of social work. They came to attend the annual convention of the American Public Welfare Association. A fine and interesting program had been prepared. At but one session however did the work and cause of the voluntary hospital receive consideration.

To this conference the council of the American Hospital Association had sent three representatives. Each discussed the problem confronting the voluntary hospital—of caring gratuitously for increasing numbers of indigent persons. But the only reply of the welfare official was, "No money is appropriated to or for this purpose."

This verbal shrug of the welfare shoulders does nothing except deepen the resentment of many in the field against officialdom's absurd attitude on this subject. Millions for non-essentials but not one cent for the hospital which bears the indigent load! Will it be necessary for the voluntary hospital through sheer force of circumstance to refuse to bear the government's load and bid it build and conduct its own institutions? If it will not cooperate in the more economical plan of utilizing institutions already built and willing to serve, this must in the end be its only alternative.

The Great Divide

THE attention of the transcontinental traveler as he passes over Western mountain ranges is at a certain point directed to a spot where water flows toward the West or within but a few feet starts its long trek to the East. This great divide is of geographical interest because of the minute physical separation at the source which is transposed into thousands of miles at the river mouths.

The great divide in hospital administration may be said to be that point which separates the business of policy making from that of administration. Starting at the board table where policies should be made, the division as to board activity and administrative execution of board edicts often represents the difference between good and bad hospital work.

Overzealous board members have not had their attention strongly enough directed to this dividing point. To forget that inefficiency follows board interference in administration is to fail miserably in the possibility of becoming a good board member. To assume that a place on a hospital board gives authority which may be translated into orders for hospital heads and other subordinates represents a dangerous attitude for a hospital trustee.

A good board member is one who realizes that the executive whom the board has selected must be given complete authority or else he will not command the respect of the members of the hospital family. The administrative and policy making waters, by employing the simile with which this statement began, may rightfully and efficiently mingle freely at their sources. They should later, however, remain wholly separated by the great divide which differentiates the making of a policy and its practical exemplification in the business of caring for the sick.

Amortization

TO CLEAR off a debt as by a sinking fund is the usual understanding of this term. In hospital practice the word presupposes that each year will be set aside a fractional part of the total cost of expensive apparatus so that at the conclusion of its expected usefulness funds are at hand to replace it.

How rarely is this common sense business procedure observed in institutions! If at the end of each fiscal year operation receipts approach expenditures all seem content. And yet within the month an outlay of many thousands of dollars may become absolutely necessary and no money is at hand to meet this requirement. As a result delay and lack of efficiency result and in the end the purchase must be made anyway.

No system of bookkeeping is sound which does not set up a reserve—a sinking fund—not to pay a bond which is known to come due at a given date but to meet a need which is almost as definite since the life of costly apparatus and equipment can be rather closely approximated. In computing the annual budget provisions should be made to meet probable bad debts and certainly there should be set aside a sum which will accumulate and will make possible the replacement of x-ray, physiotherapy, electrocardiographic and other specialty equipment which becomes obsolete or which wears out.

Imprisonment for Debt

IN THE main, hospital patients are honest. It is only the tricky, unscrupulous individual who seeks an opportunity to escape from the hospital with an unpaid bill. He it is who, apparently considering an evasion of a just claim a usual and not an entirely undeserved punishment of the institution for some real or fancied wrong, casts discredit on the whole class.

When a patient refuses to pay his bill the hospital is immediately placed on the defensive. Several courses are open to it. One is to endeavor to secure a properly executed note covering the account involved. This plan is not adopted as often as it should be. A second course is to discharge the patient and accept his word that he will later reimburse the hospital for his care. This scheme does not routinely bring results. A third method is to institute suit for the sum involved. This plan the executive hesitates to adopt because of its effect on community good will.

But any or all of these courses failing, the discharge of the offender may not be refused pending the payment of the hospital bill. Such an action is often attempted by the executive but in reality represents an implied threat which cannot be legally carried out. Habeas corpus proceedings against the hospital and its directors have on occasions been the counter thrust of the patient or his family when a discharge has been refused because of nonpayment of a hospital bill.

Moreover, unpleasant publicity always accompanies this attempted solution of such an impasse. In the end the hospital loses both in reputation and in finance by the practice. Imprisonment for debt has long since been discarded in the new world.

An Ounce of Prevention

PREVENTIVE medicine endeavor should pervade the work of every hospital department. By the same token the nonmedical administrator strives to anticipate the occurrence of accidents which may result in physical damage to his charges.

He organizes fire drills, he brings about the inspection of sterilizers, elevators, fire escapes and the facilities for storing gas cylinders, and he studies the safety of methods employed by doctors and nurses in the handling of lethal drugs. He realizes that, given the proper combination of circumstances, anything may happen in the hospital. While the spirit of preventive medicine attains its greatest possibilities in staff activities, yet it may drop to a low ebb unless attention is again and again directed to the fact that no hospital is good unless it prevents as well as cures diseases.

Of all times of the year, the spring is probably preeminent as a period in which both the wisdom and the effectiveness of preventing disease are stressed. The superintendent will do well to inquire as to what type of public health work is being practiced in dispensary and wards. Moreover, from the hospital should radiate throughout the community a strong influence which tends to make people disease prevention conscious.

It has been often wisely suggested that the out-patient department should consist of two divisions, one preventive, another curative. In the preventive might be placed the cardiac, postnatal, tuberculosis, preschool and other clinics of similar nature. The curative division would of course contain that more numerous group of curative dispensaries erroneously considered as wholly representative of out-patient work. These activities cannot successfully be combined. When this is attempted curative efforts advance at the expense of preventive.

An Anatomical Simile

FLOATING cartilages and kidneys are likely to embarrass the comfort and efficiency of the whole body. Floating, unattached and uncoordinated department heads are sure to lead to lost motion in the administration of the hospital.

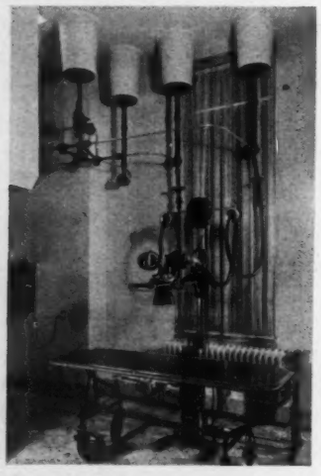
A weak executive is likely to listen to the personal pleas of the individual relative to the place which he should occupy in the hospital set-up. He requests that he be made a free agent without an administrative integration into the organization plan. Hence arise positions such as "executive assistant to the superintendent" who should be merely an office secretary or "special adviser to the board" who in reality is the watch dog of the administrator.

To create a position for a person is often a cowardly solution of a dilemna where to say "no" firmly is the only proper attitude. The so-called hospital expert who surveys and then hangs on in the not always vain hope of rushing in when the mine which he has placed under an able executive explodes should be administered some of his own medicine. Persons and departments must not be left hanging in mid-air no matter whose feelings are hurt by placing an individual in the proper subordinate place. Now is the time to consolidate administrative activities and shorten executive lines of communication.

New Viewings in X-Ray

READY for the viewing—all those desirous of witnessing the latest in x-ray equipment and departmental layout! It takes place at Polyclinic Hospital in New York, where since the first of the year new standards have been exhibited for mechanical procedure in x-ray service. The very first view serves to identify it, too, as a unit that possesses individuality and sales appeal.

By RAYMOND P. SLOAN



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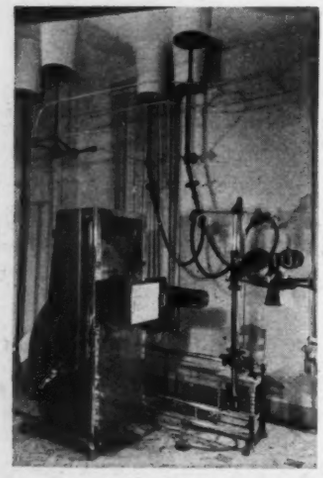

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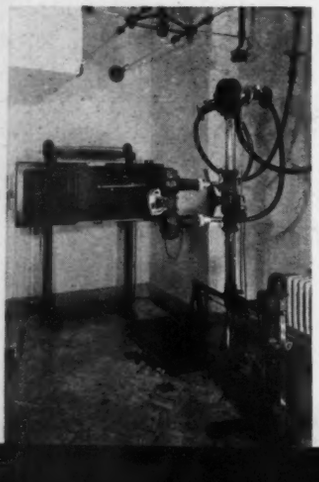

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The department has been set up in the new building which houses the clinics, with its entrance directly across the hall as one steps off the elevator. A more imposing approach is from the private patient pavilion through a spacious lounge made homelike with easy chairs and library tables — the old x-ray department as a matter of fact. Hospital atmosphere is notably absent.

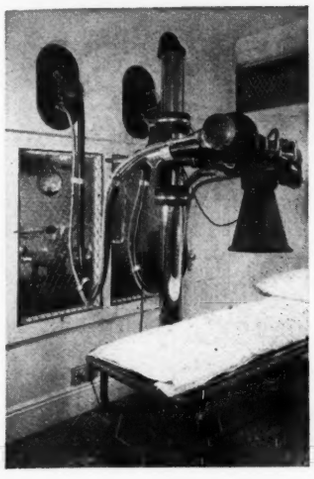
Through this lounge one enters into a smaller room designated as the director's office. It is an office in name only, however. It might be the sitting room of a Cape Cod cottage, so accurately has early American tradition been followed in its decorative treatment—pine furniture and paneled walls.

Before actually stepping into the working unit, therefore, two facts become manifest, first the accessibility of the department from the clinics and wards as well as from the private pavilion; second, the air of distinction given it through decoration.

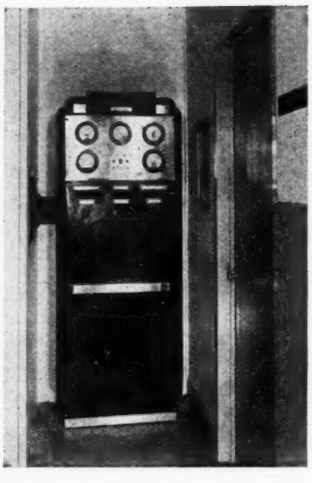
To get the proper picture of the layout of this suite, it will be helpful to keep in mind the shape of a "U," for that is precisely the form it takes. Deep therapy is handled in a basement room, also modernly equipped and especially designed for that purpose.

1 Wheel stretcher in normal operative position over the Bucky diaphragm with the tubehead centered on it. In the upper lefthand corner is the motor driven high tension switch. 2 No. 11 diagnostic table in position for vertical fluoroscopy. 3 The wheel stretcher is out of the way and the tube centered on the horizontal cassette changer for stereoscopic chest exposure. 4 Air insulated superficial therapy tubehead and stand with the diadex mobile in the background. 5 Deep therapy tubestand in the treatment room in basement; through the wire netting over the window the quadrocondex 220 kv. constant potential deep therapy generator is visible. 6 Vertical control board which automatically controls the deep therapy apparatus shown in the photograph numbered 5.

4



5



6

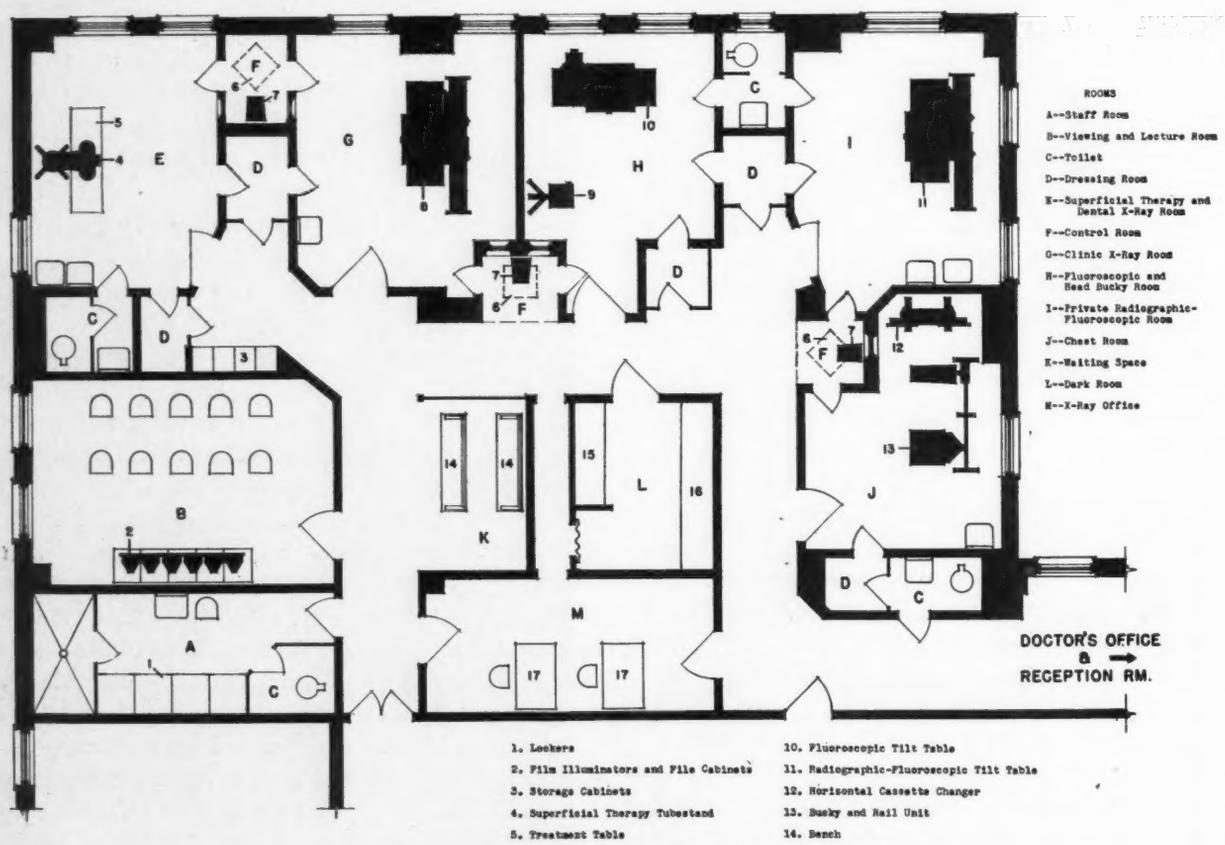
To the left as you enter from the hallway in the new building is a business office and room for files; to the right, the emergency room and chest room. Adjoining this is the main radiographic room for private patients. Next comes the main fluoroscopic room and head room. Continuing around the "U" we find the main radiographic room for clinic patients and the superficial therapy room. Then, on the other side of the "U" are the viewing room and demonstration room, beyond which are the staff dressing room and locker room. A dressing room and toilet are provided for each radiographic room.

In that section comprising the central part of the "U" is the dark room, which occupies half the space, leaving the other half as a waiting room for clinic patients. Attention is directed to the passageway provided for communication between the dark room and the secretary's office, which is also the file room.

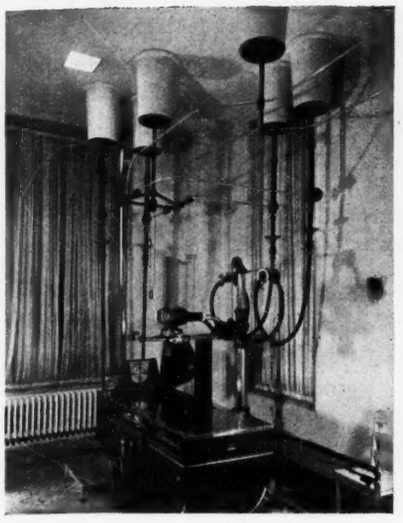
Even the most cursory view of this layout is sufficient to indicate that there is no duplication of apparatus, also that the equipment is absolutely shockproof, eliminating any possibility of accidents. Transformers are mounted in overhead cabinets, the five rooms being operated by three energy units all remotely controlled. In fact, one of the outstanding features of this set-up is the aerial system with its motor driven switches which automatically—at the push of only one button—connect either one of two rooms with a centrally located generator simultaneously making high tension connections between it and the proper tube, and also with

Viewing room helps form one side of the "U."

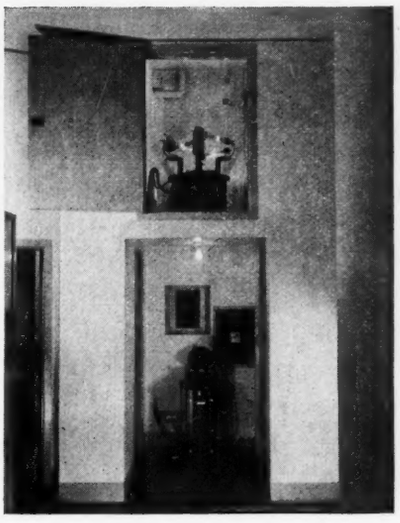
Above is the spacious lounge that forms the entrance to the new x-ray unit from the private patient pavilion. The general arrangement of rooms in the x-ray department is shown on the plan that is printed below.



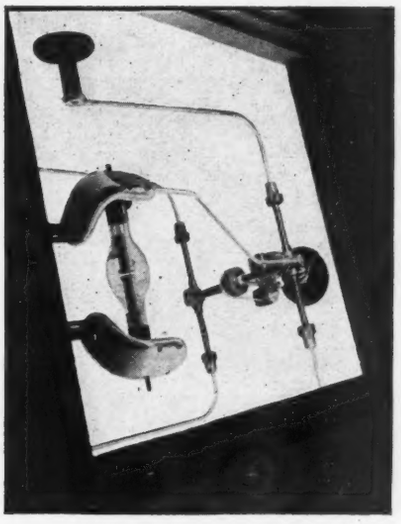
1. Lockers
2. Film Illuminators and File Cabinets
3. Storage Cabinets
4. Superficial Therapy Tubestand
5. Treatment Table
6. Transformer on Mezzanine
7. Control
8. Radiographic-Fluoroscopic Tilt Table
9. Head Bucky
10. Fluoroscopic Tilt Table
11. Radiographic-Fluoroscopic Tilt Table
12. Horizontal Cassette Changer
13. Bucky and Rail Unit
14. Bench
15. Developing Tank
16. Loading Bench and Film Dryer
17. Desk



A fluoroscopic room with diagnostic table in horizontal position.



Radiographic generator mounted in mezzanine; control board below.



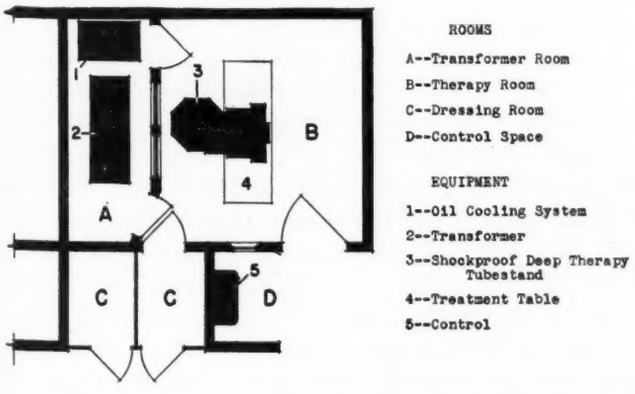
Motor drive switch located directly above one of the transformers.

the necessary low tension connections such as the timer, Bucky, stereo shifts and cassette changers.

This arrangement practically doubles the capacity of the equipment, since a patient may be made ready in one room while an examination is in progress in the adjoining one. Incidentally, it also adds appreciably to the safety of the equipment as a whole, since it is quite impossible to direct either high voltage or low voltage current to the wrong room accidentally. In addition to the stationary equipment a portable unit is provided which is entirely shockproof.

Flexibility in the layout is further revealed by the fact that each radiographic room can be converted into a fluoroscopic room by pulling down the shades. Another point which should be noted is that the apparatus is so placed that stretchers can be manipulated without difficulty.

All of the rooms are large and have outside exposure, thus assuring them plenty of light and air. Walls are finished in light gray and the equipment is black and chromium. To relieve the severity, white curtains are hung at the windows. Further decorative touches are introduced into the dressing rooms, again lending atmosphere to the department.



Layout of space and equipment in therapy room.

Deep therapy is handled in a single room with remote control cabinet downstairs. There are also two dressing rooms. An interesting feature here is the energy unit, which can be readily inspected through glass panels covered by wire netting. Tube and cables are completely shockproof.

Practical Psychiatry

Realizing that patients at the Peter Bent Brigham Hospital, Boston, would be better treated if the medical house officers knew more of psychiatry, Dr. Henry A. Christian, physician-in-chief, took up this problem with the commissioner of mental disease of Massachusetts.

As a result, four months' residence and practical instruction in Massachusetts state hospitals were provided for medical house officers at the Peter Bent Brigham Hospital. Doctor Christian incorporated in his medical service of sixteen months an additional period of four months to be spent at one of the state hospitals, the period following a four months' experience in clinical laboratory work and preceding clinical service at the Peter Bent Brigham Hospital.

This plan has been in operation for more than a year, Doctor Christian said in writing recently in the *Journal of the American Medical Association,* and is a practical means of meeting another deficiency in the scheme of educating men to practice better medicine.

As Done in Denver

By MARTHA JAYNE, R.N.

At Colorado General Hospital advanced educational programs reach classes of patients who otherwise would not be enrolled and enlightened

ADULT education courses were introduced into the Colorado General Hospital, Denver, in October, 1936. The Denver County organization offered the services of an occupational therapist to work with the patients on the women's wards. Neither the hospital nor the local organization had more than a few dollars for equipment or supplies, but through the ingenuity of the worker collections of inexpensive materials were made and the project started.

In a few months the supply closet contained a supply of materials and patterns, with simple things for patients who wanted to learn hand work, and more intricate things for experts. It was agreed that the patient might keep the articles by paying the cost of the material or the projects might be left in the cupboard to be sold at cost, to be used as patterns or to be raveled and made up again by some other patient.

The convalescent ward has become a changed place. The happiness of the patient is evident in improved mental outlook, which in turn influences his physical recovery through improved appetite and better sleep at night.

Convalescing Patients Benefit

The value of occupational therapy has long been recognized for special hospitals yet it is found in few general hospitals. On the general medical ward it now seems indispensable in aiding treatment of arthritic patients and patients being treated by the psychiatric department. For other patients it is a stimulus toward recovery when they may join in activities with others. The patients not only learn, but enjoy bringing new ideas to the group, developing initiative and a sense of personal adequacy which many times is needed by the patient who has a long convalescence or who may not look forward to complete recovery.

Soon after the occupational therapist's contribution to the hospital group was realized, the adult education directors offered the hospital a larger service. Once a week book reviews were given on both men's and women's wards. Books were sometimes selected by patients, but the series on the whole has included the better modern novels. The response of the patients is enthusiastic. Each week on the men's wards an hour's review of current events is given, and problems of the day are discussed under the direction of a leader. Occupational therapy on the men's wards is being planned. The future program also will include musical and dramatic entertainment for the patients.

What the future of adult education will prove to be is stimulating to the imagination. The Colorado Adult Education was begun in 1933 as a part of the federal emergency educational relief. Federal relief funds support the program which is administered by the state relief committee, under the direction of the state superintendent of public instruction. It gave the Colorado General Hospital the services of an occupational therapist. This program was brought to a sudden close in 1934, having lasted only a few months. After the federal program was discontinued in the hospital a volunteer worker caried on the work for several months before the program was abandoned. The federal program was reorganized later in 1934, under WPA. It was under this direction that the present and wider program of adult education was started in 1936 in the Colorado General Hospital.

An adult education program in a general hospital reaches persons who might never join a group until they have this contact. Among "down-and-outers" are many radical thinkers. By current event classes and discussions directed by well informed teachers the opinions of this group may be shaped to build rather than destroy. Patients who have had little time or opportunity are given an appreciation of better things, which need only to be looked for and are found without riches. In all it seems that a better hospital and future social adjustment is made possible.

We Call It Bibliotherapy

By HELEN ALLEN FORBES

A HOSPITAL librarian approached the bed of a man whose head and face were covered with bandages. Yes, the patient would like a book, but when his visitor urged him to select from the collection she carried, he seemed to lose interest.

Meeting with no success, she returned to the library and reported her problem. Then the head librarian, loaded with careful selections from the classics, visited the patient. Convinced that here was an opportunity to encourage good reading, she offered the man "Black Beauty." "Lady," groaned the victim, "I was just kicked in the head by a horse."

This incident occurred many years ago, shortly after Rochester's first hospital library was established. The belief that sick people should be urged to enjoy the best in literature has been replaced by realization that a patient prefers to read for pleasure. Naturally, individuals, sick or well, differ in their choice of books. Their moods vary, too, from day to day, shifting from John Galsworthy to P. G. Wodehouse, or from Zane Grey to John Masefield.

Books That Are Taboo

Since patients frequently ask for lighter reading than they would ordinarily choose, and to fill the requests of staff and employees, a patients' library should be supplied with a collection of books differing from those of a rental or public library. Caution must be exerted never to supply reading matter harmful to the patient. This restriction automatically eliminates books dealing extensively with death, surgery, or disease, and bars "thrillers" from the hyperthyroid patient.

At Strong Memorial Hospital, Rochester, N. Y., the following authors and titles have been popular, as evidenced by a tabulation of the discarded book cards over a one and one-half-year period:

Bess Streeter Aldrich, A Lantern in Her Hand; Temple Bailey, Wallflowers; Gladys Hastings Carroll, As the Earth Turns; Lloyd Douglas, Magnificent Obsession; Zane Grey, Arizona Ames; Grace Livingston Hill, Chance of a Life Time; James Hilton, Lost Horizon; Peter B. Kyne, Lord of the Lonely Valley; Charles Nordhoff and James Hall, Mutiny on the Bounty; Kathleen Norris, Second Hand Wife; Ellery Queen, French Powder Mystery; Grace Richmond, Red Pepper Burns.

The patients' library gives daily service to Strong Memorial and to the Rochester Municipal Hospital with a total capacity of 585 beds, and to 1,100 doctors, nurses, employees and medical students. The library consists of 2,500 books, 250 of which are juvenile, 125 foreign, 500 nonfiction, and the remainder fiction. In addition to the salary of a full-time librarian, the budget provides for purchase of three or four new books monthly. The money taken in as fines is available for smaller purchases. The average circulation is 1,750 a month or more than 20,000 a year.

Books popular with the majority of women patients contain one common feature—love interest. The stories also have simple settings, the characters are those of everyday life, plot interest centers in problems familiar to any reader, and the style is simple and direct. The books popular with men patients furnish adventure and excitement. Again the plots are simple, except in the case of some detective stories. The ease with which patients become absorbed in these books bears witness to their therapeutic value. The books are easy to hold in bed and have clear print.

Books appealing equally to both patients and staff were recent publications when they were placed in circulation. The experienced reader may ask for currently popular books. Whether his requests are for biography, travel, detective stories or general fiction, he is likely to be discriminating. To satisfy this demand current monthly lists of publications are studied. Likely selections are read by the chairman of book purchases and bought if satisfactory. The method of choosing books popular with less discriminating patients differs. Volumes need not be so recent and may be purchased at low cost from rental libraries or acquired as gifts.

To supply the cultivated reader it is necessary to maintain high literary standards. Selections should be made by an experienced and con-

scientious buyer. A valuable collection is gradually accumulated of genuine literature which comprises the heart of any library. An exception to the general rule that books light in weight are usually preferred for reading in bed, is "Gone With the Wind," by Margaret Mitchell. Recently this book was purchased for ambulatory patients and staff. Instead, it was requested and read by four bed patients before reaching any member of the group for whom it was intended.

After a book has been placed on the shelves, the aids may include it in daily selections for library carts. As a part of the month's training schedule for volunteer aids, the problem of book selection for the individual patient should be given special attention. Regulations may direct that a single book be left with each person, except before a week-end or holiday. Responsibility rests with the aid to suggest the proper book. The first requirement in filling a book cart is that the aid be familiar with each book she includes. Further, to encourage reading with the hospital service in mind, a card file of summaries written by various staff members should be kept, and aids should be required to contribute to this collection at regular intervals. The periodic distribution of a mimeographed "Book Bulletin" containing synopses of new books and summaries from the file is interesting and helpful.

A well directed patients' library is recognized today as an important adjunct of a hospital. It might be called a department of bibliotherapy.

Giving the Patient Adequate Night Care

THERE should be no differentiation between night and day care of patients. The hospital's responsibility is in no way lessened by the fact that most of its patients should be sleeping. Adequate care, which may be provided only through the coordination of the physical plant and bedside care, should be as available at two in the morning as it is at two in the afternoon, according to Charlotte Landt, Cook County Hospital, Chicago.

Night noises are a problem too often overlooked. The click clack of heels down a corridor would never be heard if rubber heels were conscientiously worn by all who use the corridors at night. A noise conscious personnel will not be guilty of loud talking or laughter. Proper maintenance will eliminate the dripping of water which results from faulty plumbing. Mechanical devices can be installed to prevent slamming doors. Call systems should be soundless. Switchboard operators may be taught not to ring telephones continuously.

Supplies should be made available to night nurses. Adequate nursing care cannot be given if linen is not to be had for the patient who needs several changes during the night. When a supply base is so located that it takes from five to ten minutes for the nurse to reach it, there is constant danger that something may happen to her patient during her absence.

Patients are served dinner at an early hour. Some light nourishment given to them just before lights out will often aid in inducing sleep, as will the correct ventilating and conditioning of the air in the patient's room. Night lights should be such that in a ward the nurse may take care of one patient without disturbing any of the other occupants of the room. A further point in noise control is the elimination of clicks when night lights are turned off and on.

Hospitals are dangerously understaffed at night. The night supervisor is in charge of the entire hospital, a territory so large that the student nurse is necessarily given responsibility usually beyond her ability. The shortage of nurses on floors results in the introduction of short-cut procedures that lower efficiency of the nursing service. Directly traceable also to this same shortage is the high rate of fatigue among night nurses, a state induced through rest hours passed up night after night and broken sleep during the day.

Outlining her suggestions for remedying these conditions, Miss Landt, who is in charge of nursing service at night at Cook County, placed first the importance of planning night nursing on an eight-hour schedule. Nurses doing night duty should be given one twenty-four-hour day for rest each week, a short rest period during their eight-hour shift during which time coffee or milk is obtainable, and an unbroken month's vacation.

The number of nurses, both student and graduate, on night duty should be increased. Routine duties, such as cleaning cupboards, should be delegated to untrained workers, not to night nurses. The barbaric custom of awakening patients between five and seven in the morning should be discontinued.

Labor and Philanthropy*

There should be other forms of redress than strikes for wrongs done hospital workers

By E. M. BLUESTONE, M.D.

IN USING the term "labor" I refer to hospital work and workers, regardless of whether the service is paid or unpaid, direct or indirect. "Labor" is done for the patients by those whom you, as representatives of the community, have selected as being qualified to do it.

Generally speaking, workers may be divided into two parts, (a) those who are covered by the pay roll and who draw their living directly from it, and (b) those who are not so covered but for various good reasons serve on a voluntary basis. In the use of the term "philanthropy" I refer to voluntary contributions, and contributors who help to maintain hospitals. The greater the philanthropic contribution to the hospital the more will the following remarks apply.

Some people refer to philanthropy as the "donor" and to labor as the "recipient," recalling that these so-called donors are volunteers, and the so-called recipients the working men and women who share the bounty of the philanthropist with the patients whom both serve. Such a classification is, however, as obnoxious to most progressive people as the word "charity." It certainly does not help us in our discussions with labor. Whatever might be said about the patient, no worker wants to be considered an object of philanthropy.

Let us try to clarify our definitions in another way, by saying that four parties might be involved in this discussion: (a) the voluntary contributor, whom we identify as the philanthropist, (b) the compulsory contributor, whom we identify as the taxpayer, (c) the patient, and (d) the employee who works for the patient.

My topic limits me to hospitals served more or less by voluntary effort, and I must therefore exclude those in the unique position, like military hospitals, of having a full-time staff of doctors, nurses and other personnel supported altogether by the taxpayer. Every philanthropist is a taxpayer, but not every taxpayer is a philanthropist. Labor, philanthropy and the patient to whom both have dedicated their efforts, are the protagonists of this presentation.

The voluntary or philanthropic hospital, which students of medical history concede to be one of the outstanding contributions to social welfare, is by definition dependent on private philanthropy in its broadest sense for survival. It is the bulwark of the sick poor who cannot afford the purely private hospital on the one extreme and who have not yet been reconciled to the ways of the purely public hospital on the other. It stands as a living example of what private interest and private enterprise can do for the sick. The voluntary hospital was, indeed, begotten in a noble desire on the part of a public already burdened by taxation to make voluntary contributions to the public health by providing hospitals that would be acceptable to the patient and the staff, and that would introduce at the same time the competitive spirit in hospital service.

These hospitals have again and again been threatened with dire consequences through the loss of power on the part of the contributing public to continue the process of voluntary self-taxation for their upkeep. You all remember the depression and the mental processes that helped us through with our economies. The greatest single saving could, of course, be made in the pay roll since this was the largest item of hospital expenditure. Many of us took the easiest way and reduced salaries telling ourselves all the time that our hands had been forced.

Those who felt that the voluntary hospital, like the family physician in the presence of infectious disease, bears a charmed life, and would be exempted from financial bankruptcy by a beneficent providence, were compelled to reconsider the matter in the light of the prevailing financial situation. Whether we may speak of the depression as being in the past or not, there are few voluntary

*"A Labor Program for Hospitals," The MODERN HOSPITAL, April, 1937, continued.

hospitals which are completely solvent even now.

It would, indeed, be too obvious to say that labor and philanthropy in hospitals have a common denominator of service and are often indistinguishable. Yet, during these trying times of economic unrest throughout the world, it is exactly this intimate relationship which men in the heat of passion over the class struggle are apt to overlook. We have, in fact, lived to see the day when capital and labor continue, at the bedside of the sick in our hospitals, a struggle which belongs in the political arena.

At the Patient's Cost

In the largest and one of the most civilized cities in the world, we have seen sit-down strikes in hospitals, some of them successful, and all of them fought in the presence and at the expense of the sick whom we had promised to help. The situation is more serious than many of us think when some people who have had occasion at one time or another to enter a hospital, confidently seeking relief from pain and suffering, now condone the summary abandonment of patients by workers who feel that they have a prior right to comfort.

When voluntary hospitals came into being, the motive of the founders was charity in its broadest sense. Throughout history, some of these founders have, indeed, been canonized for their service and many are those who are remembered by the grateful historian. There were no pay rolls and no class problems in the beginning. Philanthropy always kept pace with the times and finally produced the voluntary hospital that we know today.

As the class struggle intensified in recent decades, some of the workers who, unlike their predecessors, thought of themselves first, made the discovery that the philanthropist and their traditional enemy, the capitalist, were one, and began to look upon the hospital as just one more sweat shop to be destroyed, if necessary, in the mad rush to revolutionize our national economy. The capitalist-philanthropist, remembering the methods that increased his profits in business, apparently thought that he could introduce them in hospitals while taking advantage of the devotional aspect of hospital work, forgetting, for his part, that profit accrues by a far different process in the hospital than in the factory and that the hospital must be governed as a social agency and not as a business.

Labor in its finest sense had always been credited with philanthropic motives, so far as the hospital was concerned, and it seemed a foregone conclusion that the hospital worker would accept this view of his activities. That the charitable contribution made by the hospital worker in his daily rounds has not been adequately acknowledged by the community is to the discredit of the philanthropist, who seems to have been willing to accept all the credit while giving comparatively little to contributions made in actual labor.

I am referring, of course, to (a) the underpaid worker, (b) the worker who is willing to expose himself for the benefit of the sick, and (c) the volunteer on the visiting staff, though in the last instance we must concede that there are other than financial forms of recompense, such as prestige and experience.

The common denominator of service, which is applicable to labor and to philanthropy, holds equal significance for both sides, yet the partners who have pulled together through the ages appear now to be drawing away from each other. In some instances they have taken arms and declared a war to the finish, as if a criminal were on the opposing side. If the strike is to be accepted as a weapon of labor warfare in hospitals, we shall eventually find that a victory with the hospital as a battlefield may prove to be a Pyrrhic victory. What our ancestors in the hospital field never dreamt would have been permitted to happen in a philanthropic institution, actually happened a few times in recent months and there is little evidence that the public appreciates the significance of these incidents.

Public Health Demands Peace

There must be an alternative to this ruinous tendency. A way must be found to reestablish the old relationship, if for no other reason than that public health demands that peace prevail where the public health is concerned. We must agree at the outset that it is no crime to ask for an increase in wages. Sufficient food, clothing and shelter for a hospital worker and his family, a reasonable amount of time to himself and the wherewithal with which to enjoy it with some feeling of security, are his inalienable right, and it is not for the philanthropist who is more fortunately placed to deny these to him and to take advantage of his labor without adequate compensation. The very fact that the worker is at the bedside of the sick increases the responsibility for both sides. The philanthropist must not take advantage of loyalty and the worker's handicap in safeguarding his elementary rights and privileges.

Like other human beings who must work for a living, hospital employees are apt to rebel, and, when they do, the philanthropist will be confronted by one of two types of persons. These are identified by certain characteristics and sometimes according to the world outlook of the per-

son describing them. First comes the honest humanitarian with a liberal mind, the believer in that much misused word democracy, who is overcome by the knowledge of "man's inhumanity to man, to woman and to the lower animals," who conscientiously and by honest means seeks improvement.

Dangerous Propagandists

It will not do to brand this type with the same mark as the other who tauntingly agitates with half-truths and distortion of facts, for all that he can get out of it. The latter type keeps his fellow employees, or those who may be attracted by his style of public and private speaking, in a constant ferment, and plays his tune like the Pied Piper of Hamelin, and often with the same tragic results. Making promises that are often impossible of fulfillment to people whose minds are prepared by being first made unhappy is his stock-in-trade. It is of the greatest importance to the community, and vital to the welfare of the hospital, to distinguish between these two kinds of individuals. The one must not be made to suffer for the excesses of the other. With the one we can reason and come to terms, with the other, never.

The first of these types is brother by blood to the philanthropist and it is important that he be given an opportunity to set forth his case. No philanthropist may lay the flattering unction to his soul that his interest in the hospital is conclusive proof of his humanitarianism and social-mindedness, and that no further discussion on this point should be required with one of the beneficiaries of his charity. The world is changing rapidly around us, so rapidly, in fact, that we scarcely recognize our social environment from one year to the next. The philanthropist who thinks that he can sit and wait with the labor program in his hospital, while epoch-making changes in labor relationships are taking place all around him, is sticking his head in the sand, like the ostrich, and doomed to early extinction, if he persists in this kind of short-sighted strategy.

Besides, whether he likes it or not, there lies in wait for him that second individual, who has all the characteristics of the bulldog — and if you don't know how tenacious and pugnacious a bulldog can be — you should study the labor strategy of a certain vociferous full-time minority in our labor unions and you will find out what I mean. The philanthropist may well add to the liturgy of his morning prayers, and say "Oh God, let me be a true philanthropist this day, and lead me not into debate with these people."

There is no blinking at the problem. It must be faced boldly, sympathetically, generously and constructively, as becomes a group of men who are determined that there shall be no exploitation of the weak, while they have the power and the money to prevent it. This means that the employee, as well as the patient, must have the powerful protection of those who have been privileged to govern and to give. It should go without saying that one of the best ways of protecting the interests of the sick is to have a contented group of employees to serve them who are worthy of their hire.

The best type of hospital trustee, the true philanthropist, does not wait for a committee of outsiders, who may or may not have reason on their side and who may or may not be expert in hospital management, to tell him crudely and often harshly what to do and when to do it. No man need be bullied into doing something which he would readily enough do of his own accord if he had thought carefully about it at the right time. Hospital administration is the job of a professional social worker, expert in the technique of his specialty, and philanthropy, in its best sense, is the job of the governing authorities. We must leave no job for paid agitators if we can help it.

Now if, after studying the labor situation and applying the indicated remedies, we still find the bulldog in our wake, there is only one way that I know to meet him. When justice and public opinion are on the side of the governing authorities, there is nothing left to do but liquidate the voluntary hospital and transfer the care of the sick from philanthropic to public agencies. This may appear like revolutionary treatment of the problem but I am assuming, of course, that all constructive effort has been exhausted in dealing with such a cruel and inhuman situation.

Partner in the Enterprise

Obviously all effort should be directed toward the prevention of such a course by reasonable and peaceful means, in an open-minded and far-sighted way that will recognize the hospital employee as a partner in the enterprise. Both labor and philanthropy can try the process of public education and of legislation to effect improvements. However, it will not do for an answer to say that you are operating your hospitals under deficits and cannot, therefore, meet the just needs of your employees.

In those instances where employees, for one reason or another, acknowledge their own philanthropic contribution by working for minimal pay, such explanations may be acceptable, but these instances, outside of the religious group of hospitals, must be rare, and it will profit us nothing to encourage selflessness during these rebellious times. Someone remarked to me the other day

that the time may return when the sick will more and more seek religious hospitals, with Sisters of Mercy to look after them who will not, under any circumstances, abandon them.

In dealing with the problem we might as well anticipate a few of the arguments that are commonly employed by labor in its efforts to improve the working conditions of employees in hospitals. Routine hospital expenditures may be divided roughly into two kinds, pay roll expenditures and expenditures for supplies, including food supplies. When supplies rise in cost, you are dealing with an almost inflexible situation and must find ways of meeting it. You may decide to reduce the quantity and quality of food served to your patients and employees, but the chances are that you will meet the higher costs. If you should decide, however, to reduce standards of food and medical and surgical supplies you run the serious risk of reducing your hospital to the proportions of a boarding house and justified public criticism might follow.

Times change, and with them the prices of commodities, including the cost of labor. Many of us did not hesitate to reduce wages when costs were down, since this item seemed to have the characteristic of flexibility. If philanthropy with its high purposes is able and willing to find the wherewithal to meet the increased cost of supplies, it must be equally willing and, we hope, able to meet the increased cost of labor. Oscar Wilde's definition of a cynic, as a man who knows the price of everything and the value of nothing, should be remembered in this connection. The problem is basically an economic one and not as difficult of solution as the casual observer might think.

Credit Due Labor

Much credit is due to labor as well as to philanthropy for the existence of voluntary hospitals. Much criticism is, however, due to both for their failure to come to terms and make the necessary adjustments to the world in which both must live and work side by side. If capital and labor are at war, it must be fought outside of the hospital. The strike as a weapon of labor warfare in hospitals carries with it the seeds of destruction of one of the finest products of our civilization and it must therefore be condemned out of hand.

We must insist that public opinion and the public authorities stand with us in the efforts that we are making to save the hospitals from the struggle that is going on outside in the economic and political sphere. There is an international code which protects hospitals in time of warfare, and the hospital in civil life must not be treated as an exception. Just as the hospital must be nonsectarian, so must it be exempted from sectarian pressure.

Those of us who are hospital administrators and therefore occupy key positions between labor and philanthropy, must learn to bring all of our talents to bear on this important relationship. There is no room for the reactionary or for the extreme radical in hospital work. It is not pleasant for the liberal administrator, living in a rapidly changing era, to be awakened by a rude hand and to be informed that he is the symbol for all the oppression which, they say, characterizes the capitalist system. Yet that is another situation that he must face patiently and courageously. He must retain a sense of proportion and continue to be just even under provocation.

Administrative Diplomacy

I often tell the story of an employee who, many years ago, sent me a long and well written letter asking for some favor which he considered special and unusual. As I read his letter I could not help feeling that his cause was just and, as I continued, I wondered why he went to the trouble of writing at such length to convince me. "Of course," I said to myself, "this is a perfectly reasonable request and I shall grant it."

My eye then lit on the last paragraph where the writer informed me that, unless I complied with his wishes, I should be denounced publicly. I have always felt that it was to my credit that I granted the man's request in the face of his threat, knowing full well that he would refer to the threat as responsible for my favorable reply, while he would omit the other side of his story which appealed so strongly to my sense of justice. For the sake of those of you who believe that administrative ambition should be made of sterner stuff, I hasten to add that, besides granting his request, I favored him with good advice.

The other day I was invited to meet with the executive officers of an important hospital in the East to discuss their special problems with them. Since one of our hospitals had surrendered to the sit-down strikers only a few hours before this meeting, the subject of the strike was naturally on our minds.

The men with whom I met were prominent in the field of philanthropy. One of them told me that in his efforts to secure funds to support voluntary hospitals from one of the wealthiest men in this country, he was informed by this man that he would give no more and that the time had come when these hospitals should be turned over to the state, since the state was already taxing so highly for communal services.

Labor is now demanding (a) higher wages, (b) a consecutive eight-hour day, and (c) an increase

in wages in lieu of maintenance, if the employee should elect that privilege. If these three demands are met, the burden on philanthropy may become excessive and aggravate such a situation as this wealthy man is apparently willing to bring about. When I turned to one of the men at this point and said "You will have to raise twice as much money next year," he shrugged his shoulders as if to say "It can't be done."

One Who Goes Scot-Free

The philanthropist who has exhausted every opportunity to be fair in his relation to labor, may well wonder why it is that his neighbors who are at least as wealthy as he, and who contribute nothing to the voluntary hospital, are immune to the pernicious influence of the picket and the striker who will have their own way at any cost to the hospital. It is the man who does not give who has helped to precipitate such a situation, yet he goes scot-free while his neighbor bears a double burden.

It may be that I am writing these lines under the depressing influence of the occurrences that have been taking place around me. I hope that history may never record the fact that labor, which was so largely responsible for the creation and maintenance of the voluntary hospital, worked the destruction of this kind of charity.

The theory of the extremists that the philanthropist is a Robin Hood and that, as long as the capitalist system prevails, labor should be the beneficiary of all that the traffic will bear, makes of the labor problem in hospitals a game with the patient as a pawn. Such a theory naturally leads to the use of the strike as a weapon of labor warfare in hospitals and, if such tactics are successful, we shall find that the chapter for the voluntary hospitals will close before we become fully aware of the disaster which has overtaken us.

At a time when public opinion has, like the pendulum, swung to the side of labor in its age-old dispute with capital, and when public officials, possibly looking to their own safety, feel that silence is the best policy, labor could join with philanthropy in drawing attention to the fact that grievances can be adjusted and that radical measures in hospitals, such as the use of the strike as an instrument of labor warfare, are antisocial.

So far as the strike is concerned, we are glad to find that it has been roundly condemned by the courts, by such representative bodies as the New York Academy of Medicine, the coordinating council of all the five county medical societies of Greater New York, and the Hospital Conference of the City of New York. In a vigorous editorial on this subject recently in the *New York Medical Week*, strong exception is taken to this new practice in hospitals by an editor representing the medical profession in New York who realizes that there can be no such thing as a strike in a hospital without endangering the sick. This should be self-evident to the thinking public, as well as to the hospital employee, who may have been misled into thinking that there is no other form of redress for wrongs that may be done to him.

We must note with satisfaction that the legislators of our country are taking steps to correct certain abuses and that we are living in an era when social security is taking the prominent place in our civilized life that it deserves.

For the sake of the many thousands of faithful employees in hospitals, and the logic of the situation, we should state our opinion publicly that it will be a sad day in the history of the public health movement in this country when it may be recorded that the worker was successful in staging a revolution in a hospital at the expense of the sick to guarantee his prior right to comfort.[1]

Five Years' Growth

FIVE years ago a program was started by patients and staff to help readjust and rehabilitate patients in a vocational way at Niagara Sanatorium, Lockport, N. Y.

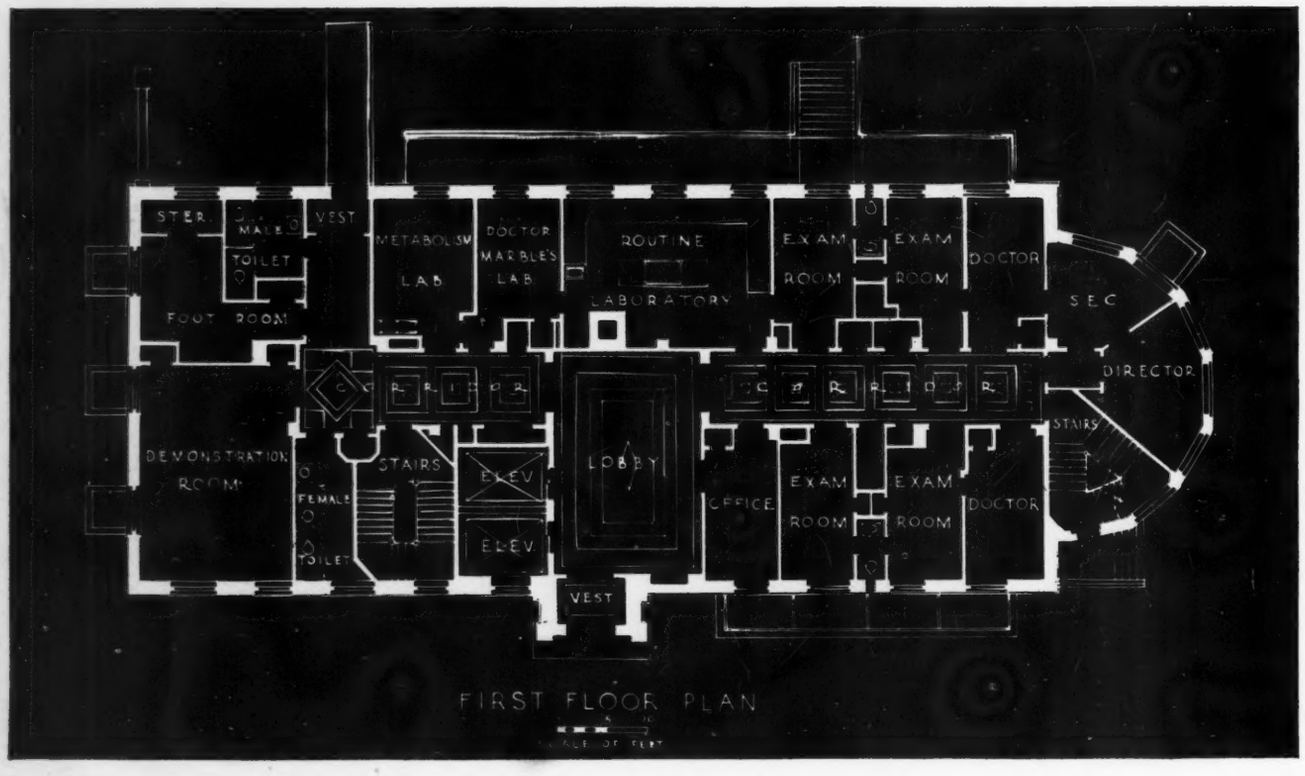
Staff members and patients, who had training in some special line, gave classes in their specialty. Classes in shorthand and typewriting were carried on sporadically. With the aid of the state rehabilitation service some patients were able to complete business courses. The sanatorium itself absorbed some of the student patients.

One course, established to train individuals as secretaries to physicians, ended by producing an x-ray technician, a laboratory technician, a light therapist, a dental assistant and a storekeeper.

The chance method of selection of courses might have continued but for a survey of the work made by the rehabilitation secretary of the National Tuberculosis Association. Because of her recommendations, the county health association is now financing the employment of a rehabilitation secretary, who guides the patients into lines of work which they are capable of following and for which there is a demand or for which a demand may be developed. She interviews patients upon arrival, and by the time they leave the sanatorium they have a knowledge of what they can do.

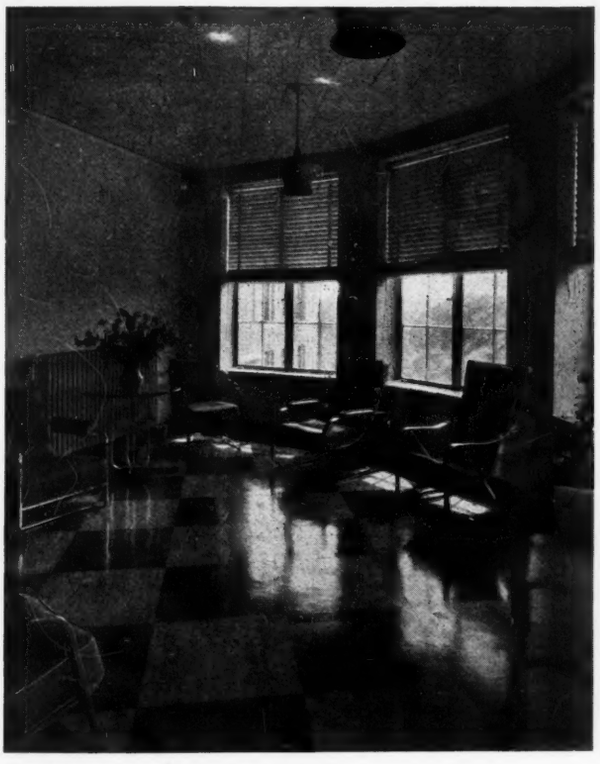
[1]Read at the meeting of the Tri-State Assembly, Chicago, May 5 to 7.

Of simple and pleasing design is the exterior of the Baker Clinic of the New England Deaconess Hospital, Boston. Limestone base and trim relieve the red brick of the structure and copper cornices are treated to match the limestone. At one end of the building is a sun room overlooking the river. A wide driveway leads to the entrance.



Presenting the Baker Clinic

By WARREN F. COOK



Solarium overlooking the river.

THE George F. Baker Clinic for the New England Deaconess Hospital, Boston, represents a unit designed primarily for study and treatment of diabetes and other chronic diseases.

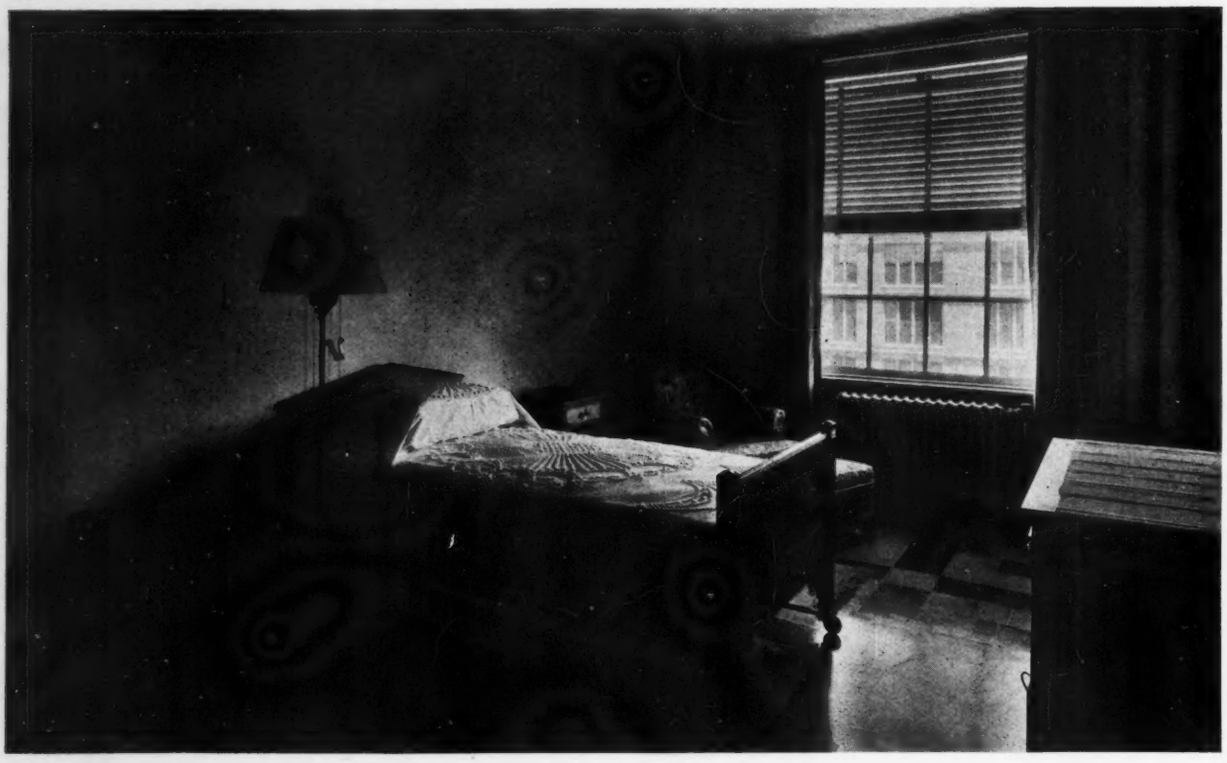
The building, consisting of basement and five stories, faces the riverway between the Deaconess and Palmer Memorial Hospitals. The main entrance, facing the Deaconess, may be approached by a wide driveway, which provides adequate parking space for both doctors and visitors, from either Pilgrim or Deaconess Roads. The exterior, of simple but pleasing design, is of red brick, similar to the present buildings, with limestone base and trim and copper cornices treated to match the limestone.

The unit is so designed that it may become a part of any future development of the property along both Pilgrim and Deaconess Roads, and is located over the junctions of the present service tunnels connecting the Deaconess and Palmer Hospitals with the nurses' home. Through this tunnel, which is used for traffic as well as services, the new unit will receive its heat, light, power, food and laundry services from the central distribution points. For this reason the basement is located at this tunnel grade with a direct entrance into it. The basement is devoted largely to services such as mechanical equipment rooms, toilets, nurses' locker rooms, incinerator, linen rooms, and animal quarters, consisting of an animal room, operating room and feed room.

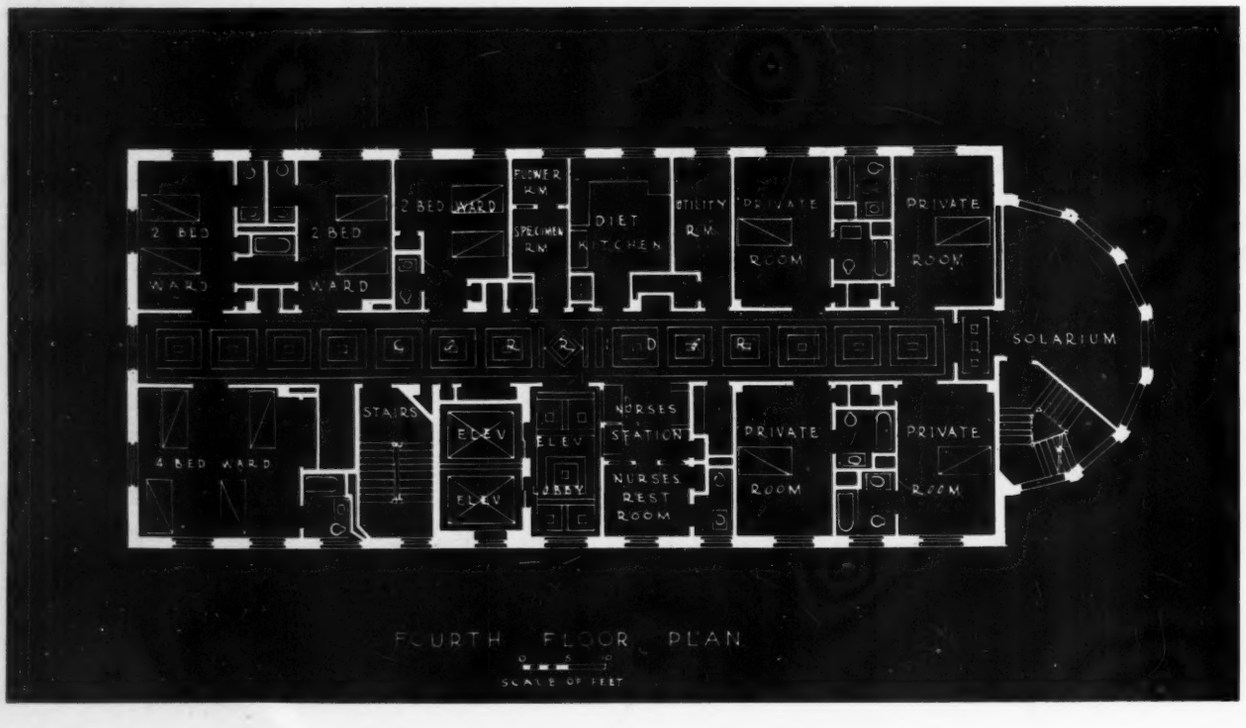
We Enter the Lobby

Approaching the building from the Deaconess Hospital, one enters through a vestibule a spacious lobby in the center of the first floor, from which corridors lead right and left. At the right is an information office and beyond, six offices and examination rooms where the clinics will be conducted and patients examined and admitted to the unit. At the extreme end of the corridor are offices for the director and secretary. Back of the lobby is a large routine laboratory where extensive routine specimen work will be done, a small research laboratory for special work and a room for metabolism tests.

At the left of the lobby are two elevators of the latest hospital type serving the various floors from basement to roof. At the Pilgrim Road end of the unit is an entrance at grade adjacent to the Palmer Memorial Hospital. On this floor are also toilets, a foot room to be fitted with latest equipment for care of the feet, and a large class or demonstration room which will be used for clinics as well as instructing nurses and patients in the care of diabetes.



In the private rooms the walls are a warm gray, and the floors of brown and black rubber tile. Gay chintz in a flower design of tan and soft rose is used to upholster the chaise longue. The furniture is of natural colored cherry. The picture on the left shows a corner of the first floor reception room. The third and fifth floors are similar to the fourth, a plan of which appears below. These floors are for patients.



One of the four-bed wards—sunny and well ventilated.

The second floor is given over entirely to laboratories for the study of disease. It is planned for twelve laboratories of different types but owing to limited funds only about one-half of the space will be utilized at present.

The third, fourth and fifth floors are devoted to patients. At the third floor is a bridge connecting with the Palmer Memorial Hospital so that the operating and other facilities of that unit may be made available when needed. In the center of each patients' floor are elevators, a nurses' station and rest room, linen room, diet kitchen, utility room, flower room and a specimen room, where specimens will be taken care of and patients instructed in taking and testing specimens.

Relatives Are Provided for

At the parkway end of the building is a sun room overlooking the riverway for the patients' use. There are one, two, three and four-bed patients' rooms accommodating approximately forty-seven patients, equipped with private toilets and either private or semiprivate baths. The one and two-bed rooms are so arranged that they may be used either as private or semiprivate rooms with private toilets or as units, so that a patient and some member of the family may come to the hospital and be instructed in the care of the patient and preparation of food. On the fifth floor is a coma and obstetric room where very sick patients may be isolated.

On the top floor are two four-bed children's wards, one for boys and one for girls suffering from chronic diseases. Between the two wards is a small dining alcove where they may obtain meals and be instructed regarding proper food. The wards are segregated from the remainder of the floor by a pair of doors. Leading directly from them is a stairway to the penthouse on the roof in which is a gymnasium for children. The penthouse divides the roof into two portions, one for patients and the other larger half to be fitted up with sand boxes and swings, as an outdoor play area for the children accessible to their wards. One of the elevators runs to the roof, making it available from all parts of the building. The entire roof is surrounded by a high wire fence, and a wind-break on the children's portion makes it safe and comfortable even on windy days.

Above the penthouse is a small fan house which houses the elevator machinery and the mechanical fans ventilating the laboratories, hoods, diet kitchens, utility and specimen rooms and toilets throughout the building.

The architects for the building were Coolidge, Shepley, Bulfinch and Abbott, Boston.

With the Roving Reporter

Great Days at Hackensack

Great days these at Hackensack, N. J. All sorts of ceremonies attended the opening of the new wing of the Hackensack Hospital, including an outdoor circus staged by the women's auxiliary. Everyone joined enthusiastically in the program arranged to raise funds to furnish the new building. But more of that later.

Right now we are interested in that bus load of attractive girls leaving the hospital, destination unknown. Just as we thought — nurses going excursioning, but excursioning with a particular mission — to learn of life.

So much hustle and bustle attended the get-away that there was no time for particulars. So we asked Marie Wooders, director of nursing, to tell us about it in detail, which she proceeded to do promptly. (See page 60.)

Messenger of Good Will

Hackensack Hospital has an emissary of good will that needs no introduction to those in the community. For the benefit of others it might be explained that it is a little magazine issued regularly each three months and called the *Hackensack Hospital Quarterly Bulletin.* Started several years ago by one of the young doctors on the staff, it has grown steadily, and today under the editorship of another member of the hospital staff, enjoys a circulation of approximately 4,000. It is distributed to members of the women's auxiliary, the trustees and contributors to the hospital. The total cost is $85 or $90 an issue.

There are many things to be said in its favor, but perhaps the most outstanding is that it eliminates the need for publishing an annual report. One issue is devoted exclusively to the annual statement. Saving on this expense puts less financial strain on the publishing budget. Furthermore, it is highly regarded as a valuable link between the hospital and the community.

Much of the effect of this miniature magazine is gained by the liberal use of pictures. These are sometimes of individuals who have rendered an outstanding service to the hospital or of groups of personnel at graduation or new classes as they enter training. The text is gathered and presented on the assumption that there is nothing quite as interesting to the individual as the sound of his own name. "Good publishing sense," we call it.

Those Buffalo "Blues"

A song with some such title might well be written about the attractive entrance hall of the Children's Hospital in Buffalo, N. Y. It would not be a "blues" song as we have come to know them, however, but a gay melodious melody, punctuated by the ripple of children's laughter.

Mrs. Evangeline Nye, superintendent, has selected a typical Della Robbia blue against a white background for color accent in her foyer, creating a homelike atmosphere which carries through the entire institution. Wicker furniture, chairs and tables finished in this soft shade look particularly cool and inviting. Even the scrap basket standing by her desk becomes "blue" for the occasion. On the walls two Della Robbia plaques proclaim the source of the inspiration.

First choice for the color of the month, therefore, goes to blue — particularly as applied to children's departments. But it must be well chosen.

Yonkers, First Stop!

"Open house" at St. John's Riverside, Yonkers, N. Y.! It was the answer to an unusually large number of cars lined up in the parking space out front on one of those first warm days of spring, when coats come off and colds come on.

Captain Warfield, who stages two such gala events, one in the spring and another in the fall, finds it the best good will builder ever, to say nothing of an incentive to a thorough spring and fall housecleaning. He won't commit himself to how much picking up must be done after some 200 or more people have inspected the building from cellar to attic. What matters, anyway, so long as they actually get on speaking terms with the institution. And they do, believe it or not—most intimate terms, judging from glimpses of elderly ladies examining closely specimens in the nurses' classroom and casting hesitant eyes about the morgue.

Incidentally, let it be said that St. John's morgue is something to see. So proud is he of it that Captain Warfield keeps the door open deliberately so that they who pass may stop and admire.

Among those invited to attend these semi-annual parties are parent-teacher groups and members of the graduating class of the high school. The youngsters may get the notion to become nurses. Who can tell? And does it make a hit with the mothers to find on the writing desks provided for the students in the corridors outside their bedroom doors printed cards which read: "This desk is placed here for your convenience and with the understanding that if you live away from Yonkers you will write to your mother or someone at home at least once each week."

As the afternoon wears on, footsore and weary, but filled with enthusiasm, everyone returns to the spacious lounge at the end of the main hallway to be refreshed with tea, coffee and cakes, all attesting to the efficiently conducted extracurricular activities of the dietary department. About five o'clock everyone calls it a day—a day well spent for hospital and community alike.

Teaching Our Trustees

An invitation is extended to witness something new in trustees' meetings. The very novelty of the thing attracts. Apparently there is becoming manifest a growing need for greater understanding and a broader knowledge of present day hospital service on the part of our directors. They could stand, it appears, some rudimentary education.

So the Methodist Episcopal Hospital in Brooklyn, N. Y., is making its monthly trustees' meetings educational. On each occasion an outside speaker is invited to discuss some phase of hospital work. Group hospital insurance and its benefits to the hospital were covered not long ago by Frank Van Dyk, executive director of the Associated Hospital Service of New York. Another time David H. McAlpin Pyle, president of the United Hospital Fund of New York, outlined certain activities of that organization and described new obligations which face hospital board members in these changing times.

Proof of the pudding lies in its eating! Methodist Episcopal directors now eat regularly once each month while becoming informed on hospital affairs. Result: attendance has increased almost 50 per cent.

What Price a Laboratory?

Usually the demand is for self-maintenance. Another philosophy would let the hospital economist worry about laboratory upkeep. In any case the struggle goes on for methods to increase the laboratory's income

By H. R. FISHBACK, M.D.

WHAT are the sources from which the laboratory derives its income?

In the earlier days much was expected of the laboratory as a business. Consequently big business methods were often used to expand it. One of these was the hiring of a hustling laboratory director on a percentage basis. He was given either a fixed percentage of the laboratory income, the hospital assuming the running expenses, or he assumed the expenses and paid the hospital a percentage of monthly or yearly income.

Certainly, the emphasis here might be expected to be on the business side, since the success of the laboratory was measured largely by the amount of money brought in. Sometimes payment to the hospital was made on the basis of patients in the hospital only, and the laboratory director was allowed to keep the income from outside patients. In such instances the hospital was prejudicing its interests in the almost certain campaign which would be waged for outside work.

The percentage method is rarely found nowadays in the larger hospital which has a full-time laboratory director. More frequently it is used when several small hospital laboratories, often in different small towns, are directed by one pathologist or when a hospital laboratory becomes one of a group controlled by a commercial laboratory.

The commonest method of deriving laboratory income is the separate test charge, in which each patient pays for his own requirement. When test charges were relatively stable and the amount of work from a given number of patients under known circumstances was calculable, the income-debit ratio of a laboratory lay within predictable limits. With the chaos of recent years, however, that has not been possible. With the great decrease of pay patients, and the lessening of work per patient, has come in some areas marked decrease of the charge per test. In many metropolitan districts the price scale has declined from 30 to 80 per cent on most laboratory tests. This has not been the case, however, in outlying districts with less competition.

Under this system, in spite of lessened costs, it frequently happens that less work is ordered for the patient in straitened circumstances than he requires, because the attending man is trying to keep the costs within the patient's means. Further, even this minimal amount comes as an "extra" charge upon the patient, and only the diplomatic collection clerk can realize what annoyance such "extras" are to the patient. Nevertheless this system prevails in many hospitals.

A fixed laboratory fee for each patient is collected in some hospitals. This is found to vary from two to five dollars, generally according to the amount of study offered but sometimes depending on the financial status of the average run of patients in a hospital. The type and often the number of tests given for this fixed fee are usually limited. Formerly this often allowed only blood counts and urinalysis but it has been extended to include serologic and bacteriologic work and occasionally some blood chemistry.

Most patients' laboratory needs fall within the scope of work offered and they gain by getting more work than the fee actually pays for. More work is thus thrown upon the laboratory, and occasionally the enthusiasm of the attending physician who wants to order "everything,"—often repeated—on all his patients, must be moderated to actual requirements. The laboratory gains, however, in having a dependable income.

A variation of this method is the fixed sliding scale of laboratory fee for each patient. In this method a fixed but smaller sum is charged for the

first few days, usually three, and a small sum per day thereafter up to five or seven days, with no charge after that. This system offers conditions similar to the preceding one, except that it appears to equalize somewhat the laboratory fees as between the short term and the somewhat longer term patients. Likewise the patient whose stay is protracted is saved from too high laboratory fees. The laboratory has double protection on the average case in that the heaviest laboratory work comes in the early diagnostic period of the patient's stay and further in that the average patient's time in the hospital is around eleven days.

The plan of charging a fixed room service fee per day gives the advantage that the quoted price of the room is the total hospital charge. The usual extras, such as laboratory, x-ray, physiotherapy, medicines and dressings are all included in the "room service" charge. This plan has been applied in only a few hospitals as yet. It seems to be more easily worked out in a community where the economic level is above the average. The calculated service rate might vary in different hospitals. Always, however, the fixed charge must carry some weighted addition for variation of demand with a constant overhead and for a contingent fund. More work will certainly be given to the laboratory, and again, as with the other fixed charge plans, some equitable moderation of unnecessary laboratory work must be made. As to the number and variety of tests that might be performed on a patient in a short time, it seems that careful control might be a necessary safeguard for the hospital in the strictly diagnostic case with a stay of only two to four days.

On a Budget

Again, the laboratory may be budgeted out of total income without regard to its earning capacity. This method of laboratory finance is most often found in hospitals supported by taxes or by endowment. It would be the ideal from the pathologist's viewpoint if funds were sufficient to make available adequate personnel and equipment for laboratory study on all cases. Too often, however, the opposite result is met. Expenses are shaved to the minimum without regard for scientific service, resulting in an understaffed, poorly paid and overworked laboratory personnel. Sometimes this economy throws a heavy burden of routine laboratory work on the interns without sufficient time allowance given them for such work and without any real supervision of the work itself. The harm done to the cause of the patient by this demand on the interns is a recognized one, which is usually glossed over under the guise of giving the intern a more thorough service.

The debit chalked up against the laboratory on hospital accounts is often sketchily calculated. Occasionaly even the laboratory director has not taken the time to acquaint himself with the expense of running his department. This is true because the laboratory often integrates with other departments so closely that the idea of digging out what it adds to the total expense has not even been considered.

Question of Salaries

The biggest item is salaries. In a hospital whose laboratory is acceptable to the American Medical Association the director must be a physician with special knowledge of clinical pathology. The requirement of special training has not been associated with better pay. On the contrary, the average pay is well below the predepression figure. Many hospitals of middle size have found it difficult to pay a full-time pathologist's salary and are working under part-time direction.

Technicians have been similarly afflicted with salary cuts, and have had their field of work overrun by poorly trained girls. By forming an associated group with rather high standards they are protecting their interests.

In a well organized laboratory technicians should be relieved of nontechnical duties. Much work can be done by unskilled workers, at a considerable saving of salaries.

Nurses are usually assigned to laboratory duty when a training school is run. Neither the maintenance cost nor other theoretical value of the nurses' services should be charged against the laboratory, because their laboratory service is part of their training. To give this the laboratory force is continually breaking in raw recruits to some knowledge of the fundamentals of obtaining specimens and handling them properly. The laboratory really should get credit for this teaching work.

Interns assigned to laboratory service also belong in the educational category. They are there to learn, and to learn at the expense of the laboratory. However, in some hospitals, books are balanced with a charge against the laboratory for services of assigned nurses and interns.

The next big expense heading is that of supplies, including chemicals, glassware and other apparatus, serologic and bacteriologic supplies, and animals and their upkeep. In most independent hospitals supplies are bought by the pathologist. Nowadays, when fairly uniform price lists are available from reliable companies there is no reason for losing money on purchases.

However, the questions of the quality of bargain materials, and often of how long ahead supplies may be stocked when prices are reasonable, are often met here. Hospitals associated with universities may be serviced by a general purchasing department. About the only thing to recommend this is the rebate for purchasing in large lots. Often the time consumed in waiting for material is a nuisance, articles slightly different from those ordered are bought, or cheap materials are bought.

What Rental Charge Includes

Rent for space occupied is a fair charge against the laboratory but the price is occasionally a bone of contention. Rooms given to the laboratory are in many cases leftovers, or space that could not be used for patients' rooms, so that private room charge or any figure approaching that, should not be made. It seems fairer to compute the rental charge on the basis of the average price of floor space in that vicinity outside the hospital. Perhaps even less than that in case the laboratory quarters are cramped and unfavorably located.

The rental charge should of course include heat, electricity, plumbing repair, janitor service and redecorating, all of which come under the general requirements of keeping the quarters fit for their intended use.

Servicing and repair of the equipment belonging to the laboratory are a proper charge against it. Under this heading come the servicing of electric apparatus such as centrifuges, ovens, incubators, water baths and refrigerators, the sharpening of section knives, repair of microscopes or regrinding of lenses, or other necessary repairs.

Depreciation is always a somewhat arbitrary figure but with considerable investment in heavy apparatus which wears out gradually, it is necessary to estimate the number of years of wear. The day by day breakage and wear-out of minor materials such as glassware, and other small things, are taken care of in the expense of new supplies.

When depreciation is charged this should be credited to a laboratory reserve fund. Otherwise when the time comes for replacement of apparatus on which a depreciation charge has been paid, the laboratory will be charged for it again under new supplies.

Interest on the investment in laboratory materials should be charged against the laboratory. While this is often omitted in hospitals, certainly it would never be overlooked in a private business. If inventory is made once a year, the interest charge can be calculated from the average of the inventories at the beginning and end of the year.

The pathologist's work in a hospital includes many things for which the laboratory receives no monetary credit, but instead a debit for the expense involved. Among these are the general morgue expense and autopsy service. Not only is the expense one of money invested and of servicing the ice boxes, but where the work demands it, special help may be required for autopsies, for cleaning up the morgue, and for care of instruments. Handling of the gross and microscopic tissue preparations from autopsies is also done at considerable expense. Yet the whole autopsy service is recognized as a purely educational function, for the benefit of the staff and the hospital as a whole.

When the pathologist or his assistants officiate at clinics or conferences for the staff, or hold conferences for interns or classes for the nurses, the special tissue preparations, lantern slides, slide projectors and other materials used are a charge against the laboratory. Some credit adjustment should be made in the interest of fairness. Perhaps all such expenses could be grouped and entered under the general heading of educational activity.

The acquiring of books and periodicals for the laboratory is a proverbially difficult matter. On the average, the pathologist is expected to supply his own reference books and often those for the technical workers as well. Periodicals are in the same category.

Too often the matter of charges against the laboratory is fixed entirely in the hospital office without the laboratory director having any part in deciding the amount of charges. The laboratory director deserves to know the operating figures of his department, and should be consulted about any change of the economic base. Usually he is the one held personally responsible for the success or failure of his service.

Departmental Use of Billing Machines

Billing machines, commonly used in department stores, are of distinct advantage in hospitals when departmental charges are sent to a central bookkeeping department to be posted on individual patient's accounts. Each department has a machine for its own use. Duplicate charge slips are left in each machine for auditing purposes; the original is sent to the bookkeeping department to be posted.

In order to segregate and correct errors quickly, each department uses a different color charge slip. This has proved advantageous in correcting and tracing errors, both in posting accounts and at point of origin.

The charge slips merely carry information as to service rendered, (operating room, x-ray,) the patient's name and room number, and the initial of the person making the charge slip. — *George D. Sheats, Baptist Memorial Hospital, Memphis, Tenn.*

Ethnology—Firsthand

By MARIE A. WOODERS, R.N.

THERE is no profession in which the need for broad and sympathetic understanding of all peoples is more imperative than that of nursing. Hospital executives, although realizing this situation, have been at a loss to know how the material for this appreciation could be provided.

In some cases, required readings and occasional studies of various racial groups have been included in the nursing curriculum to supply this deficiency, but these efforts have been meager and spasmodic and the results poor. Nevertheless, the material for such studies is not so elusive as is generally supposed and in every community, faithful search will disclose sufficient material to provide human laboratories for the study of peoples. Naturally, hospitals near larger cities will discover proportionately greater possibilities. And for the hospitals near New York there is a wealth of material which remains unused though its value for the training of nurses in human sympathies cannot be overestimated.

Visits to Foreign Quarters

At Hackensack Hospital, Hackensack, N. J., for many years trips were planned through various laboratories showing the preparation of hospital materials. In addition some trips were organized for the study of hygienic conditions in relation to city planning. Students were also urged to visit the various museums.

Within the last two years, however, the importance of this extension work has been increasingly emphasized and a consistent program has been arranged for the definite study of peoples, their beliefs, their social backgrounds—all aiming towards broader understanding and sympathy. The student who enters the school of nursing, usually comes with definite prejudices regarding other peoples, their faiths and customs. As with most persons of limited background and experience, she is convinced that her beliefs are right and other beliefs wrong. A nurse must be sympathetic with the patient and she must anticipate his needs and desires. Only a broad understanding will enable her to do so.

For this reason our program of extension trips has been divided into various fields—religion, social welfare, sanitation, art and other subjects. Perhaps a few examples of these study excursions into various fields will offer the best testimony of our approach to the subject.

One of the first trips we took, and one of the most interesting and instructive, was the study of living world religions aside from Christianity and Judaism. Our bus left Hackensack Hospital at 7:30 a.m. on a Sunday morning. We went directly to the Mohammedan Mosque in Brooklyn. This was a Moslem Holy Day and by special arrangements we were permitted to attend the services, and observe these people seated on their prayer mats, absorbed in their devotions. Since this was a study group a meeting was arranged for us following the services when questions could be asked. A number of the congregation spoke on Mohammedanism and answered questions.

Following our luncheon we went to an assembly hall where a doctor, educated in one of the large universities of our country and a retired surgeon spoke on the Faith of Islam. Following this we visited the Jain Temple at the Metropolitan Museum. A Chinese poet then spoke to us at the museum, on the Way of the Tao, also interpreting for us the art in the Chinese gallery. From there we went to the Roerich Museum where Frances R. Grant, vice president of the museum and an authority on Oriental philosophy, lectured on this subject. The major part of the lecture was presented in the Tibetan library, with its Tibetan scriptures. We then were taken through the parts of the art gallery which were pertinent to the Asiatic ideals. This portion of the trip was, perhaps, the most enlightening and inspirational.

We had our supper at an Indian restaurant, where ancient Hindu music was explained and played by Sarat Lahari, on ancient Indian instruments and we ended the day with a visit to the Zen Buddhist Temple. The service was conducted by Rev. Sokeiann Sasaki, priest of the Tyame Zen Buddhist Temple of Tokyo, Japan, who spoke on the Way of Life of the Buddhist, as well as on the Shinto Faith, the faith of his fathers.

By visits to New York's cosmopolitan areas Hackensack student nurses' education is extended through a broad understanding of all types of peoples

On one of these Oriental trips the service at the Mohammedan Mosque was replaced by a visit to the Ramakrishna Center where Swami Nikhilananda spoke on Hinduism and the Vedantist Teaching.

At another time, we were able to include among our speakers, Haridas Muzumdar, a disciple of Ghandi, who spoke on "Ghandi and India's New Parliament."

Another trip was devoted to the study of the Jewish and Semitic peoples. In the morning we visited an Assyrian Apostolic Church where the Aramaic language is still spoken. After our lunch, we visited Temple Emanu-el and Beth-el. There were no services, but the beauty of the temple itself was an inspiration.

At the B'nai B'rith Club, Dr. Harold Corn, of the Jewish Historical Society, gave an illustrated lecture on the rôle of the Jewish people in early American history. We then visited the Jewish Religious Educational Center where Dr. Leo Jung, director of the center, spoke to us on Judaism. He described and explained for us, the Jewish Passover Supper, called the Sader. He then took us through the library, with its many old Bibles and volumes of the Talmud, affording us one of the most illuminating moments of our trip.

We enjoyed a kosher cafeteria supper at the Young Men's Hebrew Association, and after the supper a Jewish doctor recently exiled from Germany, and a witness of the Nazi régime, addressed us. Following this, we heard a most interesting parley between an Arab savant and a learned Jew, on the present Palestinian conflict. This was not a debate, but a fine discussion. All of our lecturers were most gracious about answering questions and conducting forums after their talks.

The group was taken into a Catholic church where the Catholic services were described. They were also taken into a Protestant church where the Protestant viewpoint was presented.

A third trip was the study of the various "isms" of the day. At 9:45 a.m., in the Club Cubano, a professor of psychology of New York University, who had just returned from Spain, talked to us on "The Struggles to Maintain Democracy in Spain and Europe." He had been in close contact with the Popular Front Government and gave us an interesting and vivid picture of the problems facing these people.

Then, to get the German background, we visited various German shops and stopped for lunch at a German restaurant where a young Nazi spoke on "Adolph Hitler's Tactics and Victories for the New Germany." Our next lecturer was the executive secretary of the American League Against War and Fascism. He spoke to us on "Trends Towards Nazism and Fascism in the United States. Can It Happen Here?" We then visited the Hispanic Museum where the Sorolla paintings were interpreted for us.

Because of our program, an appropriate dinner was served to us in a Russian restaurant, after which, at the Communist local headquarters, the "Achievements in the Soviet Union" were described by a leader of the group who had been in Russia. He also told of the progress and achievements of Communists in the United States. We went to the Socialist headquarters where a representative of Denmark spoke on "What Socialism and the Cooperatives Did for Denmark and Sweden." The day ended at the New School for Social Research where we saw a presentation of Danish and Swedish folk dances, in colorful native costumes.

We Go Slumming

It is impossible in the short period of time at our disposal to give the students more than an introduction to these various situations. However, the opportunity of meeting these people in their own surroundings and learnings of their ideals and aspirations, not only gives the students an idea of their aims and hopes, but gives light to their reading and permits them better to evaluate their professional experiences. It also gives the students some mutual interests outside of their profession which they can discuss, as too frequently nursing is the only subject which the students have in common.

Our trip to the slums provided another opportunity for study. In the morning we visited a housing project in Harlem, after which we went to the Henry Street Settlement, where we were most graciously received and where we were told of the purpose of the settlement and guided through its many departments, all of particular interest to our group. We went to the Seamen's Institute, "The Home Ashore for Sailors," where we were

served an excellent dinner at a nominal fee, and two Episcopal clergymen talked with us on their work at the institute. We were taken through the training school for sailors, dormitories, the chapel and the lighthouse.

We then visited several slum tenements which were condemned by the housing commission in 1901, as unfit for human habitation, a box apartment, railroad apartment, a house in the backyard, a dumb-bell apartment and the Knickerbocker Village. We went through the lower East-side district crowded with pushcarts and people selling their wares. The group was permitted to go through "first houses," the new apartments which have been provided at a nominal cost. We also visited flophouses on the Bowery, cubicles which serve as dormitories for migrants.

At Madison House a worker spoke to the group on "Social Settlements, What They Are and What They Could Do." Following dinner, an investigator for home relief spoke on "What Being on Relief Does to Families." The last thing on this program was a visit to the All Night Mission on the Bowery, where men sit up all night to get in out of the cold.

It is difficult, by merely telling of the itinerary of our trips to transmit the amount of information that is assimilated. Of the greatest value in these trips is the opportunity given to the group to ask questions freely, at the end of every lecture. The trips which we took were planned in cooperation with the director of the Reconciliation Trips in New York. Many college students joined our group.

After two years of these extension studies, we feel convinced that any school which is failing to give its students the advantage of these experiences is losing a great deal. They give student nurses a broader and better understanding of people. Because of the heavy program of study which our curriculum carries, these trips must be taken on Sundays during the preliminary period.

We hope that within the next year or two, our trips may become more closely correlated with the schedule of study. They may, perhaps, not be quite as full but will be more intensive. We also hope that in the senior year, special studies and trips can be taken through our prisons and opportunities provided for research into community problems and social reform.

We are already convinced that the trips thus far undertaken provide the students with a profound sense of sympathy and a new humane approach to their profession.

Voluntary *vs.* Legislative Licensing

IN A number of states efforts are now being made to pass special legislation for the licensing of medical technologists on the same basis as has been done for physicians, pharmacists and nurses. Such a movement should be discouraged. Since 1928 a voluntary agency for this purpose has been functioning successfully. The American Society of Clinical Pathologists through its board of registry has established the machinery for ensuring the proper qualifications of clinical laboratory technicians and issuing certificates to those who pass muster. Over half of the medical technologists in hospitals and a large number working in medical schools, clinics and under private physicians have received their proof of competence from this truly national registry.

The advantages of this voluntary system are:

1. The certificate is valid everywhere in the United States and Canada thus saving technologists who are usually in moderate circumstances the trouble and expense of securing a license from each state to which they may happen to move, and they frequently do move.

2. Political pressure and other abuses cannot flourish in an office under direct control of a scientific organization.

3. The qualifications as determined by the board of registry are uniform in all parts of the country, eliminating partiality toward or prejudice against any region or state.

4. The American Medical Association, the American College of Surgeons and the American Hospital Association recognize and endorse the Registry of Medical Technologists and recommend to hospitals that all their clinical laboratory help carry a certificate of qualification from this registry.

5. Acceptance of the registry certificate eliminates duplication, waste efforts and unnecessary legislation.

6. A vital defect of the state licensure of technologists is that it permits them to conduct their own laboratories—a function entirely out of their sphere as it constitutes the practice of medicine. This danger is entirely obviated by the code of ethics of the Registry of Medical Technologists.

Guardians of Safety

Responsibility for prevention of accidents within the hospital rests largely upon the nursing staff and demands the highest quality of personnel

By ANNA D. WOLF

IT has been estimated that 90 per cent of accidents are due to unsafe acts or practices of individuals as compared to 8 per cent due to unsafe physical equipment of building, and about 98 per cent of all accidents are preventable.

In giving consideration particularly to accidents in hospitals from the viewpoint of the nursing service we bear in mind these data and consider them from the standpoint of those affecting patients and their friends and those relating to personnel.

Any untoward activity of the patient or reaction to treatment should be considered as a potential accident, and deserves thorough study with remedial measures against repetition.

In reviewing the reports of such cases one finds about 83 per cent of the incidents related directly to activities which may cause or result in falling with subsequent possible injury; 17 per cent to other types such as burns, cuts, sprains, scratches and pin-pricks.

The majority of patients admitted to hospitals have required bed rest; the minority are privileged to be up either for limited activity or as they desire. Any patient who gets "out of bed" without order is a problem to the nursing staff and requires particular care. Each case must be considered by the staff as a potential accident case, irrespective of the cause or results of the activity. In the December, 1936, issue of The MODERN HOSPITAL the problem of patient care is excellently discussed in an article entitled "Why They Fell Out of Bed" by Constance Haigh, R.N. and J. M. Hayman, Jr., M.D., of the University Hospital, Cleveland.

Factors which should be given consideration are the type of bed and mattress used. Narrow, high beds to which patients are unaccustomed may be a real cause of part of the difficulty, as well as the newer types of mattresses with inner springs or made in two parts, springs and pads, which undoubtedly afford greater comfort and ease for the patient but are very resilient and buoyant. The psychologic effect of bed sides is an element with which to reckon as patients frequently resist them. The matter deserves and is receiving particular and constant consideration from hospital and nursing administrators and every effort is being made to control the possibility of such accidents through more vigilant care by personnel, medical and nursing, therapeutics, the use of bed sides of canvas or other materials and, if absolutely required, personal restraints which allow some freedom of body movement.

Detailed studies should be made to determine causes and precautions to be followed which would reduce to a minimum untoward activities of patients.

Patients who are allowed to be up need particular watchfulness and care on the part of the nursing staff as apprehension, general weakness and even fainting may cause accidents. Those using crutches, others ambitious to become independent require assistance to prevent their falling. The condition of the floors, often highly polished, and the use of scatter rugs without nonskid pads may be direct causes of accidents; objects misplaced, spilled water or solutions left unwiped add to the problem.

Burns as a result of treatment are considered a disgrace by the nursing staff yet they do happen at times. The use of heat in its various forms, dry or wet, a frequent type of therapy, or the use of chemicals are usual causes. Although burns may result from carelessness in procedure, undoubtedly the debility of the patient, the condition of the skin and frequency of the treatment are largely contributory. Increasing use of electrical appliances in hospital procedures presents the need for even more vigilant and careful service to prevent burning.

Smoking in bed, a privilege allowed patients more often now than ten to twenty-five years ago, is a serious problem to the nursing staff. To control smoking patients may be requested to limit smoking to certain hours of the day and evening;

cigarettes, matches or lighters may be removed from the patients' bedsides. This usually aggravates patients and they may secrete their supplies, further increasing danger of accidents. A smoldering pillow caused by a lighted cigarette stub and a sleeping patient is a picture not to be forgotten. This is the kind of accident likely to happen at night, at which time a limited number of nurses are on duty and the frequency of their visits to patients is necessarily reduced.

The tragedy caused by the combustion of an oxygen tent reported recently is the type of accident which, although guarded against constantly in hospital services, may be caused by secretion of matches or a lighter in a patient's room. Such apparatus is tested and examined before and after use and operated only by those instructed in its application. Cooperation from staff, patients and visitors can be secured through careful instruction and supervision. Specific warnings posted in conspicuous places where inflammable equipment is in use many deter careless or ignorant acts of individuals.

Miscellaneous activities in nursing may be productive of minor or serious accidents, although they are infrequent considering the innumerable times they are performed in services. A hypodermic needle may be imperfect and snap off when injected; thermometer or glass irrigating nozzle may be cracked and break while in use; a caustic solution may be splashed near a patient; an examining table or wheel chair may tip if its supports are not secure. A constant check on equipment, prompt repair, supervision and careful performance of services are the best controls against accidents which lie largely in the hands of the nursing service.

Precautions Against Human Error

Errors in medication which occur infrequently are guarded against by every possible means. Strict regulations in writing orders, detailed and errorproof techniques in carrying out the procedure, and complete attentiveness to the task at hand are the best safeguards against such mistakes. Special precautions, as coloring certain solutions, the use of particular kinds of receptacles for others, and the specific placement of highly potent drugs are used to promote safety. Many errors may be made by the confusion of patients, misreading the label, miscalculating or misinterpreting orders and trusting memory in pouring the drug. Contributory causes are generally haste, interruption, inattentiveness or concentration on other elements in the situation which distract a person from the immediate requirement. The chance of human error must be reckoned with and every precaution taken to avoid serious consequences.

Placing responsibility for prevention of accidents among patients completely upon the nursing service requires a high quality of service. This may be disadvantageously affected by rapid turnover of the staff, inadequate and limited personnel and long hours of work. If instruction and supervision are to be considered primary requirements of the prevention of accidents to patients a true corollary would be a regular, sufficient, unfatigued and competent staff upon whom reliance may be placed.

Personnel Must Be Protected

Incidents which may result in injury to the personnel of the nursing service in line of duty deserve consideration. The careful reporting of any such occurrence is a fundamental requirement in the control of the situation. Importance must be attached to what commonly may be thought a minor injury and investigation should determine as far as possible any contributory factors as well as direct cause, so that remedial measures may be instituted to prevent repetition.

In an analysis of reports of such incidents 34.2 per cent were found to result from cuts; 16.9 per cent from falls; 13.9 per cent from various causes resulting in contusions; 11.8 per cent from burns; 8.8 per cent from pricks of pins or needles; 14.4 per cent from miscellaneous causes. Proportionately the largest amount of time lost was due to pin pricks.

Cuts assumed a prominent place in this list and were produced largely by mishandling of knives, glassware, razor blades, and from the rough edges of tables, enamel ware and other equipment. Lost time from these cases was nil.

Pin pricks, anathema to the nurse, may have most serious consequences. Careful instruction in the use of pins, and also the selection of a good steel safety pin to be used for thick layers of materials, if coupled with careful technique, have proved particularly helpful in controlling this troublesome problem.

The causes of burns resulting largely from the handling of caustics, inflammable materials, electrical appliances and sterilizers, are most frequently found to be carelessness in handling the material or equipment; haste, excitability and pressure of work were contributory factors of importance.

Falls are generally caused by "slippery floor," "rug slipped under foot," "turned ankle in haste," "slipped on water splashed on floor" and infrequently "fainted and fell" or "tripped over some equipment that was misplaced." Speed and hurry

are two factors constantly contributory; it has been interesting to note that the type of shoe worn by the nurse is not frequently found to be a causative factor as so often in the case of visitors to the hospital who may have such a mishap. The type and applications of floor polish and the schedule of cleaning directly affect the incidence of falling.

Lifting of patients or equipment may be one of the most serious occupational hazards of nursing as strains and hernias may result. Nonemployment of the physically impaired, careful instruction in the principles of leverage and adequate human and mechanical assistance are the best preventives. Unfortunately most mechanical devices for the lifting of patients are cumbersome.

Other occupational hazards are presented in caring for disturbed and delirious patients. Striking, biting, and hitting with near-by objects by patients are possible occurrences which the nurse must guard against. The removal of articles likely to be used for missiles and the use of unbreakable materials and medical and nursing measures are usual precautions in the care of patients.

The day's work in nursing includes innumerable chances for accidents unless skillful, conscientious and careful service is given. Nursing is usually rendered under constant physical and mental strain, pressure, haste and tension. The nurse must work with considerable speed yet should appear unhurried and be attentive; she must keep her mind constantly on her patient's condition and reaction yet at the same time be acutely aware of the physical surroundings; at times paradoxical situations occur but her activity must result in safe therapy for the patient and safe precautions for herself. The habitually careless individual has no place in such a field as nursing; the one whose mind is readily diverted from the task at hand or whose personal and social interests make her less acutely aware of her responsibilities will probably be a liability; the other who is ignorant of and irresponsible for the danger incident to the care of patients and in the use of all equipment should not continue in this service.

The responsibilities of the nursing service directed toward safety for patients and personnel should be centered in:

1. Adequate numbers and discriminating selection of all personnel from the standpoint of personal and professional fitness.
2. Detailed instruction of all personnel and patients.
3. Meticulous and detailed workmanship.
4. Constant and careful supervision of the service with constructive criticism.
5. Elimination of those who evince repeated irresponsibility and carelessness.
6. Careful selection, check up and repair on all equipment.
7. Complete and detailed investigation of all incidents which may result in injury to those involved.
8. Remedial measures against subsequent recurrence.
9. Building up and establishing a consciousness on the part of every individual that safety is the criterion for all activities.[1]

[1]Read at the meeting of Greater New York Safety Council, Inc.

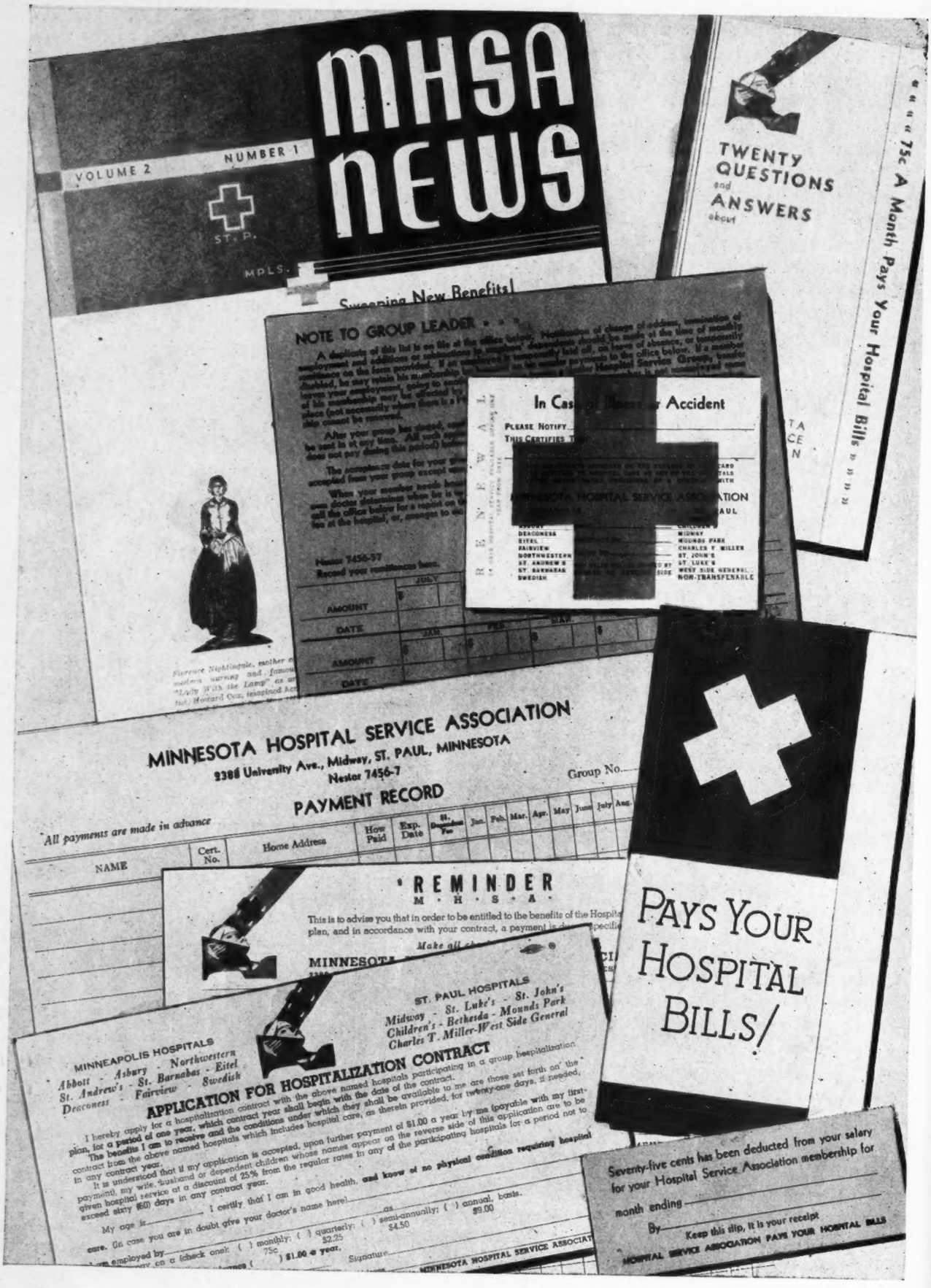
Cubicle Isolation at Mount Sinai

AT Mount Sinai Hospital, New York City, the staff was confronted with the problem of having inadequate isolation for about one-half of the beds in the ward for infants and children under three years of age. After the isolated beds were occupied, infants brought in for admission had to be turned away because of inadequate isolation facilities, even though there may have been empty beds at the time. The expense of building large cubicles was temporarily prohibitive.

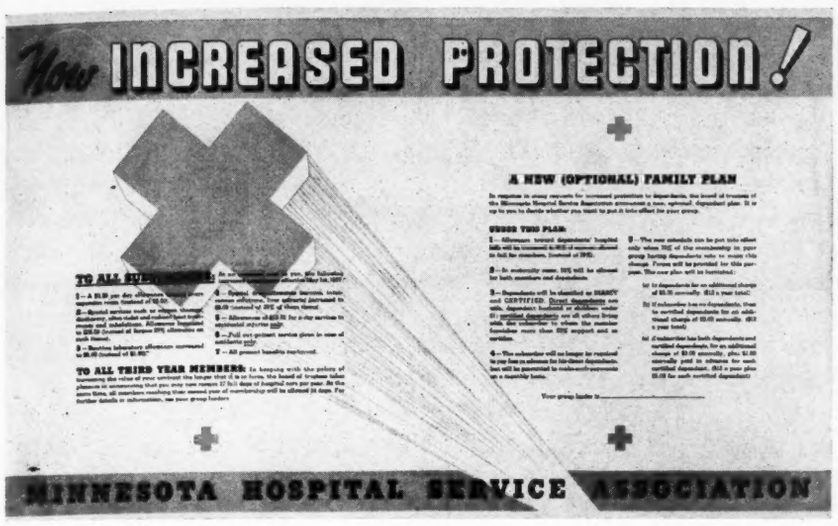
Mount Sinai decided to have two units of five beds each, which could be attached end to end to form a single unit of ten beds. Both units were mounted on wheels with a diameter of 15 cm. so they might be moved about, and rolled to the outdoor porches. Each bed measures 100 by 50 cm., and the height of the window is 80 cm. These dimensions were selected to facilitate management of the child by nurse or physician.

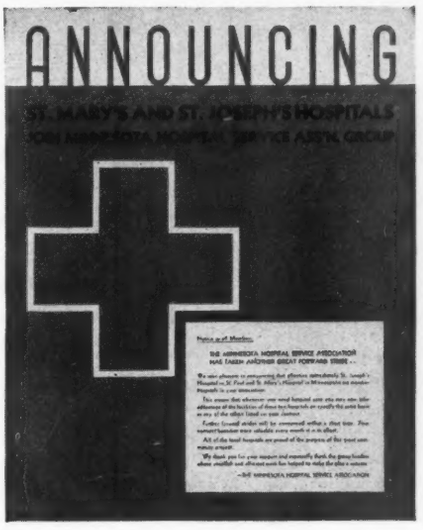
For bottle feeding the window is raised just a little, allowing the nurse, to put her arm through the opening and hold the nursing bottle. With the other hand she can lift the pillow and support the child's head and upper part of the body. In this way the nurse's face remains outside the cubicle, separated from the child by the glass window.

Mount Sinai is convinced that the new cubicle system is not only suitable for general use in infants' wards but is especially fitted for wards for the new born in maternity clinics. A complete tabulation of results in this experiment is described in the *Journal of the American Medical Association.*



Various record forms and pamphlets used in the promotion of the Minnesota Hospital Service Association.





New Line of March

for Group Hospitalization

By E. A. VAN STEENWYK

ALMOST every hospital service association in a major city in the United States has developed plans for the extension of the hospital service idea to its surrounding area. In the Twin Cities, the association was originally named the Minnesota Hospital Service Association so that it might provide service to hospitals beyond the limits of the Twin Cities. New York City's association already has extended its field to the surrounding area. Cleveland and Boston both plan to do the same thing.

A large number of communities have by now formally requested that some way be worked out so that they might participate with the Twin City hospitals in a broadened group hospitalization project. The earliest of these, the Wesley Memorial Hospital at Wadena, is ready at the present time to begin its hospital service plan. Another more recent request has come from the Lake View Hospital at Stillwater, also ready at the present time to begin work. Other communities include Mankato, Owatonna, Bemidji, St. Cloud and Winona. Many others are in various stages of developing a plan.

It is not the purpose of the Minneapolis or St. Paul hospitals to say to residents in other communities of the state, "We offer the services of nineteen Twin City hospitals for the payment of only seventy-five cents a month." As a matter of fact, requests have often come from employees in many industries in smaller communities of the state asking that affiliation be worked out between the Twin City hospitals and these particular industrial groups.

To all of these, the Twin City hospitals have said, "Unless your community hospital develops its own hospital association, or develops a relationship with the Minnesota Hospital Service Association, the Twin City hospitals do not wish to be in a position of appearing to invite your people to our hospitals to the detriment of your local hospital and medical group." The only reason that Twin City hospitals have been interested in a statewide development has been to assure Minnesota of the continuation and extension of the same kind of nonprofit organization as exists in the Twin Cities.

Development of a federation of Minnesota plans was provided for in a legislative bill which failed of passage. Because it seemed unlikely that the federation idea would be worked out, it has been necessary to work out alternative methods to ex-

tend the hospital service idea to Minnesota communities.

One alternative is to provide for associate memberships in the Minnesota Hospital Service Association. The hospitals in outside communities would, under this plan, undertake the entire development of group hospitalization within their own communities, and underwrite the entire liability for hospital care necessary for their sub-

HOSPITAL SERVICE CONTRACT

CONTRACT NO._____ GROUP NO._____

In Minneapolis:

ABBOTT HOSPITAL
ASBURY HOSPITAL
DEACONESS HOSPITAL
EITEL HOSPITAL
FAIRVIEW HOSPITAL
NORTHWESTERN HOSPITAL
ST. ANDREW'S HOSPITAL
ST. BARNABAS HOSPITAL
SWEDISH HOSPITAL

In St. Paul:

BETHESDA HOSPITAL
CHILDREN'S HOSPITAL
MIDWAY HOSPITAL
OSAS T. MILLER HOSPITAL
MOUNDS PARK HOSPITAL
ST. JOHN'S HOSPITAL
ST. LUKE'S HOSPITAL
WEST SIDE GENERAL HOSPITAL

Hereby severally agree to give hospital service through any one of the above named hospitals, upon the terms and conditions set forth on the reverse side of this contract to_____ hereinafter called the contract holder, employed by_____ for a period of one year, from_____ to_____ in consideration of the payment of $9.00 annually ($1 per year additional for dependents' benefits) payable_____ according to the terms and conditions herein set forth.

Given under hand and corporate seal this_____ day of_____ A.D. 19____

By MINNESOTA HOSPITAL SERVICE ASSOCIATION
the above named hospitals' several agent.

Attest: A. M. Calvin Jos. G. Norby

Countersigned by _____

THIS CONTRACT IS NOT VALID UNLESS COUNTERSIGNED BY THE EXECUTIVE SECRETARY.

scribers. The Hospital Service Association would simply make its staff available in the Twin Cities for help and guidance. No one would be sent out from the Twin City organization into the communities under this plan.

Such a method has many points in its favor. First, it means that the already existing Hospital Service Association in the Twin Cities would not have to make up the deficit on any associate group. Second, each community would definitely know and accept responsibility for the promotion of its own plan.

The chief disadvantage of this method is that it does not provide a basis for determining which communities should develop plans and which communities should wait. This leaves the field open for commercial promoters.

The second alternative proposal, which has not yet been approved by the board of trustees of the Minnesota Hospital Service Association, is simply to extend the present field of operation into the outlying territory with the one provision that subscribers in communities affected be provided service only in the hospitals of their own communities except in case of accident or emergency or upon the advice of their local physician. Under such a plan, all subscription fees would go directly to the Hospital Service Association. All payments made to the hospital would be made from the central office. All billing would be done in the same office. The entire mechanical set up, record keeping and all, would be done by the larger organization.

This method has many advantages and some disadvantages. The first advantage is its simplicity and the consequent low cost of administration. If each community had to develop its own administrative set-up, it is not unlikely that administrative expenses would be far greater than payments to the hospitals would warrant.

The second advantage is that a uniform plan would be offered throughout the state maintaining uniform schedules of benefits to subscribers.

The third advantage is that all communities would benefit through the diversification of risks. Wadena may in one year have an unnatural health experience. By developing such a plan, Stillwater, the Twin Cities and such other communities as are affiliated would help Wadena carry the load. Representation on the board of trustees would be given to the outlying hospitals on exactly the same basis as hospitals in the Twin City area, that is to say, two representatives would be chosen from each hospital.

The essential disadvantage of this particular set-up is that it may place too much emphasis upon the responsibility of the larger organization. The hospitals in outlying communities may rely entirely upon it for the promotion and development of local hospital service associations, the benefits of which are primarily the concern of the communities themselves.

Most communities have favored the latter type of development, but up to the present time no action has been taken by the board of trustees of the Minnesota Hospital Service Association approving this method. The committees that have been engaged in the work are, however, recommending that the board approve such a plan.

A promotional cartoon.

Two main problems present themselves in applying the hospital service association idea as it has developed in urban

centers to rural areas. The first is the simple matter which population distribution itself represents. The promotion of hospital service plans in urban centers has been greatly facilitated by the fact that large numbers of people could be reached through a single campaign. The development of rural areas will require a different type of campaign for varying communities. The problem that farmers represent is only one of many problems that will have to be worked out in developing a plan for these areas.

It seems unlikely that farmers as a group can be reached on an economical basis at the present time. Farmers as a group will wait until residents of smaller communities have thoroughly tested the plan. Once the plan has been tested and the farmers' enthusiasm has been aroused, there will be no question about their participation in local units. The problem of collection and selling is also part of this first difficulty.

For Employed Groups

The second important problem to be worked out in rural development is to determine a basis of selection which will develop a plan as sound as that used in urban centers, that of enrolling only employed groups. This can be done with a degree of certainty even in the experimental stages by plotting out every area to be covered into geographic units, according to the population in these units. The plan would then be presented to each unit, subscribers being accepted from the individual unit only when it has complied with the requirements laid down.

This may mean that instead of asking for 40 per cent participation as we do from employed groups in the Twin Cities, we may ask for 70 per cent participation. It is apparent that the margin of safety will have to be increased in some way, because many of the factors operating toward successful application of a simple standard of selection in employed groups do not operate in geographic areas. It is reasonably certain that if a person is employed that he is in good health. It is also reasonably certain that an employed person is less likely to use his own time to be cared for in a hospital. It is reasonably certain if a person is employed in an industrial or office group that his age will range somewhere from eighteen to sixty-five years.

No such degree of certainty of any of these factors can be relied upon by taking simple geographic areas. This means that comprehensive analysis must be made of every community before operation is begun, because it is essential that every plan in Minnesota develop soundly and securely. It won't do to have even the smallest community in the state develop a plan that fails. It will do us all immeasurable harm.

No one ever doubts, in view of all the circumstances, that some method of providing hospital care to the moderate income producing group will have to be developed. This may be done by communities themselves working through their voluntary hospitals and utilizing existing equipment, or it may have to be worked out with an entirely new set-up, the state probably playing an important part by paying for the service or providing it through taxation.

If the voluntary hospitals are going to be secure in the development of hospital service association plans, then broad long-time planning with regard to all possible contingencies will have to be undertaken. Whether we wish to recognize it or not, voluntary hospitals as they are today have outlived a period. If the voluntary hospital is to be retained as a part of American community life it will have to conform to the new social demands that are now evident. We must plan now to provide adequate care to the entire citizenship of the state — farmers as well as industrial and professional workers and small town residents as well as residents of larger cities. For our time, in this state, the public will best be served by the preservation and extension of the voluntary hospital system through a coordinated group hospitalization project.[1]

A Question of Ethics

Is it ethical for a physician to refer dispensary patients to his own office? This problem confronts every hospital that conducts a dispensary, and it is extremely difficult to solve. The confidence of the patient in the physician and the implication that every dispensary physician possesses the highest standard of ethics are involved.

The superintendent of an Eastern hospital points out that dispensary abuse by the physician should be dealt with promptly, but the dispensary management should guard against favoritism. Should inquiries be made at the dispensary concerning the name of a capable physician, the patient should be referred either to the dispensary, the visiting staff list or to the telephone directory.

Often under the guise of affording better treatment than is procurable at the hospital, the patient is referred to the doctor's office. This practice would be harmless if it could always be ascertained that no fee was to be charged. Sometimes the patient becomes discouraged by waiting his turn and requests a dispensary physician to treat him in his own office. In such a case, the wise physician will refer the patient to the dispensary director who, satisfied with the fair dealing of both the patient and the doctor, acquiesces in the suggestion. A deliberate attempt to refer a dispensary case to a physician's office for the purpose of collecting a fee should be strictly forbidden.

[1]Excerpts from a paper read at the meeting of the Minnesota Hospital Association, Rochester, May, 1937.

To the Employees of the Hospital

You, as well as the management of this hospital, are aware of the efforts now being made to unionize hospital employees in Chicago. It seems advisable, therefore, that the management should make a clear statement of what it feels it owes its employees, and also what it believes the employees owe the hospital.

There has been suggestion, but no direct statement, that the hospital, in its relations with its employees, comes within the scope of the National Labor Relations Act, otherwise known as the Wagner Act. The hospital management does not believe this to be the case. The hospital is not engaged in interstate commerce. It is not a business, or an industry, in the accepted sense of those terms.

However, the management of the hospital does not desire to make this an issue. It is willing, and eager, to treat its employees in accordance with the soundest public and employee relations policies, to the limit of its financial ability. It considers that you as employees have certain rights which may be summarized as follows:

1. You are free, and are requested, to discuss with the management, in any way you please, matters affecting your employment. You may discuss such matters personally, or you may select some other individual, committee, or organization to do it for you, if you believe your interests will be better served by so doing. The management acknowledges your right to bargain collectively through representatives freely chosen by you without dictation, coercion, or intimidation. The management will talk with you personally, or will negotiate with the representatives of any group among you so chosen, subject to recognition of the principle that the right to work at our Hospital is not dependent upon membership or non-membership in any organization.

2. You are privileged to join or to refrain from joining any lawful organization. No employee or applicant for employment will be discriminated against because of membership or non-membership in any such organization.

3. You are entitled to receive wages (including meals, room, etc. as the case may be) as high as prevail generally in the Chicago hospital field, for work like yours performed under like conditions, insofar as this is commensurate with the institution's ability to finance its operations.

4. You have a right to hours of work which are as short as the peculiar conditions of hospital service will permit, recognizing that emergencies require overtime work.

5. You will be employed steadily and continuously throughout the year subject only to variations in the demand for hospital service, provided that your services are satisfactory.

6. You will receive due recognition of ability, efficiency, physical condition and personal habits in promotions, necessary lay-offs, and re-employment. Special consideration will be given to seniority and to your social and economic responsibilities.

7. You are entitled to receive health protection through physical examination and immunization whenever necessary. Due regard will be given the assignment of employees to work to which they are physically fitted.

8. Every effort will be made to give you an opportunity either through training or experience to improve your skill so as to enable you to become eligible for promotion.

If there are other points, not listed above, which are important to you, the management will be glad to consider them. Our aim is to have satisfactory wages, hours, and working conditions, subject only to the limitations of hospital finances, and the legitimate interests of the patients, the public and other groups involved.

Certain inescapable responsibilities and obligations fall upon a hospital. These arise because patients come to the hospital with varying degrees of sickness, disability, and injury. They entrust themselves in a very real way to the ability, integrity, and sense of devotion of the hospital medical staff and personnel. Regardless of outside situations, such as floods, riots, civil commotion, industrial strife, etc., these patients must be given the best possible care required by their condition day and night during their hospital stay.

No one is forced to accept work in a hospital. When he does enter the hospital service he automatically shares in the assumption of these responsibilities with his fellow employees and the management. In view of these facts, the management feels that the following is a fair statement of your obligations toward the hospital.

1. To render loyal and efficient service for the full working period specified for your position and to be ready in genuine emergencies to work as long as may be necessary to safeguard the welfare of patients.

2. To follow faithfully the instructions of the hospital management.

3. To do everything possible to promote good feeling and pleasant relationships among all employees, between employees and management, and among the working force, patients, and public.

4. To give reasonable notice of intention to leave the service of the hospital. After giving such notice, the employee should continue at work as usual for the remainder of his stay.

5. To refrain from any joint action with other employees which will cause an interruption of any phase of the hospital's service and to do nothing whatever to jeopardize the safety, welfare, and recovery of hospital patients.

Our hospital is what is known as a "voluntary" hospital and as such is not operated for profit. No individual derives any financial benefit from the capital invested in this institution. In other words, the profit motive is non-existent. Some of our service is given without charge, or for less than it costs. But this does not release us from our duty to be prepared to render prompt and complete service at all times, day or night. Such service is frequently on a "life or death" basis, and must not be interrupted or impaired for any reason within human control. All these things you know to be true and you have demonstrated your willingness to measure up to the standards of service required.

If you are a member of a union, or if and when you are asked to join a union, we suggest that you consider well all the matters we have presented to you and that you then decide whether, in order to get a "square deal", you think it necessary to belong to a union with the obligations and expense involved.

We firmly believe that any adjustments in wages, hours, working conditions or other matters affecting an employee can be worked out as above outlined through direct dealings of employees with the management. It has been, and will continue to be, our purpose to provide adequate wages, reasonable hours, and satisfactory working conditions to the extent that our financial condition will permit.

Your loyal, humane, and efficient service is appreciated and is essential to the work of our institution and to the welfare of those we all serve. We, on our part, will do all we can to promote your well-being and your best interests.

The foregoing statement was prepared by the Chicago Hospital Council and the Chicago Hospital Association and distributed by member hospitals to their employees. It constitutes part of the report of the Committee on Personnel Relations of which Dr. Arthur C. Bachmeyer is chairman.

A Million Volts for Defense

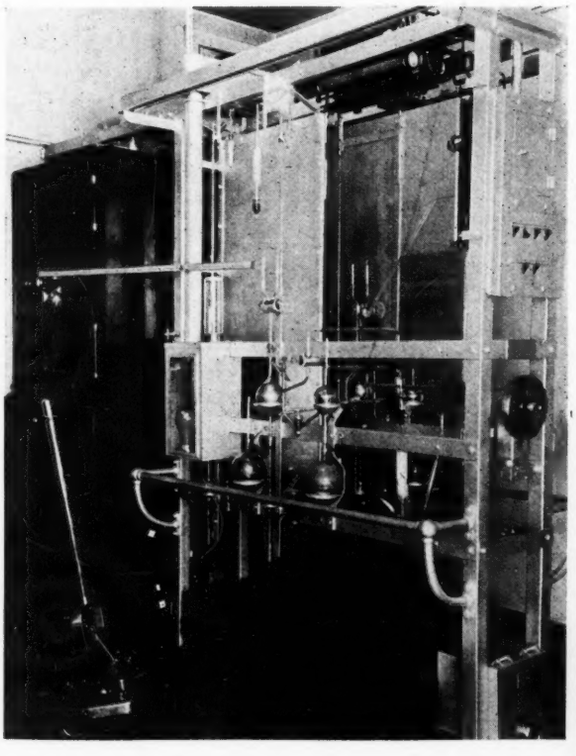
By HERINA I. EKLIND, R.N.

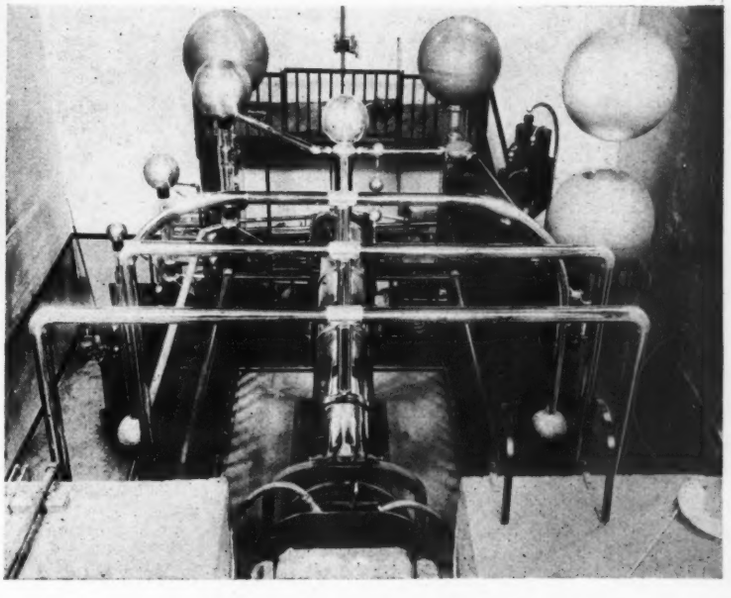
THE tumor institute of the Swedish Hospital of Seattle, Wash., was started during 1932 as a center to handle cancer problems. In the future pure research facilities are contemplated for development of remedies. Its ideals have been sufficiently broad to allow use of all agents shown to be of value in eliminating the disease.

The rapid and steady growth of the institute has been due in part to its policy of cooperating with the general medical profession. It is always willing to aid with its facilities any member of the profession in the advice, care or treatment of a patient. During the first four years of its existence approximately 2,000 patients were on its records, the majority of whom were referred by and treated in conjunction with 475 different physicians.

In order to justify this confidence the Swedish Hospital has spared no expense in developing the institute. Its personnel is composed of a well trained cancer therapist and a radiologist, both physicians, a technically trained physicist and his assistant, two nurses and two secretaries. The time and energies of these persons are devoted entirely to the institute. In addition, the institute enjoys facilities of the entire hospital, from the visiting staff, the pathologist, the roentgenologist, the laboratory and surgery staffs. Besides facilities afforded by a modern 250-bed hospital, of which it is a part, the institute has a special building to house its staff and equipment.

The main necessity for this building is the large 800,000-volt x-ray tube, one of the most powerful in the world. Twelve inches in diameter and 14 feet long, it is built in five separate sections, four of which are glass cylinders 2 feet long. The fifth is a water-jacketed metal cylinder housing the target, located at the grounded end, and enclosed in a 6,000-pound lead housing mounted in the roof of the treatment room. The lead housing is designed to allow a limited beam of x-rays to be





The 800,000-volt x-ray tube shown in the picture on the right necessitated the erection of a special building to house it. The closest section is the water-jacketed metal cylinder housing the target. Just beyond can be seen the four glass cylinders, each 2 feet long. The patient is in a room below. The other illustration shows the radium vault and the cart that is used for transporting radium.

projected in a vertical direction into the treatment room and to prevent stray radiation from reaching anyone other than the patient.

Since various parts of the tube are cemented together with wax, which is melted in place with a blow torch, it is necessary that the tube be connected to a set of pumps which continuously evacuate it while in operation. A very high vacuum is maintained, the pressure within being of the order of 0.000001 millimeters of mercury.

The tube, seen in one of the accompanying illustrations, is mounted horizontally 17 feet from the floor in a specially designed room 27 feet high, 27 feet wide and 35 feet long. Since a small amount of x-rays are liberated in this room, its walls are of concrete 12 to 18 inches thick to prevent radiation from scattering. In the rear of the room are transformers, condensers and rectifiers, generating the 800,000 volts used.

At the extreme rear are two tubes which may be connected to the high voltage generator. Both are used only for physical research, one being an x-ray tube, the other an ion tube or "atom smasher." As additional protection, the room is closed with a 1,500-pound lead door which operates switches disconnecting high voltage the instant it is opened.

Protective Devices

The treatment cubicle is a concrete cell 7 feet high, 7 feet wide and 10 feet long. The walls are 2 feet thick and the floor 3 feet of solid concrete. This thickness of concrete has a protective equivalent of 2-inch lead walls and a 3-inch lead floor, which would have weighed thirty tons had it been lead. A saving of approximately $6,000 resulted from use of concrete.

The lead housing for the target of the tube is in the roof of the treatment room. Attached to the housing is a cone system for controlling the size of the x-ray beam, a motor driven lead shutter for turning the beam on and off and an ionization chamber indicating on the control board the intensity of the x-ray beam.

Located in the beam of radiation above the ionization chamber is a filter equivalent to 5.5 millimeters of lead, the purpose of which is to filter or absorb the non-penetrating or burning type of radiation. One of the virtues of this type of x-ray tube is that its design allows the use of large tube currents (ten milliamperes) which in turn produce high x-ray intensities, permitting use of the heaviest filter available for therapy.

A motor-driven table raises the patient into position for treatment. A periscope in the rear wall of the room allows the operator to observe the patient, who is alone while being treated and closed in by a 3,000-pound lead door. On the control board are instruments informing the operator of factors pertinent to operating the tube.

Directly underneath the treatment room is an experimental laboratory. Through a port in the treatment room floor a beam of x-rays may be projected for measurements or other experimental purposes. Two Wilson cloud chambers are housed here by which pictures of atoms, electrons and various ionizing radiations may be obtained. A spectograph, various measuring devices and a 200,000-volt x-ray machine also are available.

Advantages of Machine

This supervoltage machine replaces the large radium packs used in some foreign clinics. It is more economical, the treated area can be better localized and treatments can be given in shorter time. For deep-seated tumors inside the body, it allows a greater dose in the tumor with less damage to the skin and overlying structures than lower voltage machines. It is particularly valuable in tumors of the bladder, cervix and uterus. A 200,000-volt x-ray machine of a standard commercial make is available for ordinary tumors and a 130,000-volt machine for superficial therapy.

Certain cancers can be more advantageously treated by radium, which forms an important part of the armamentarium of the modern cancer clinic. The only radium emanation plant in the Northwest is at the tumor institute. It is a Failla semi-automatic emanation plant in which the radium is stored and radon, the first product of disintegration of radium, is obtained. With this gaseous substance any type of applicator desired can be made.

The greatest advantage is the production of gold radon seeds which may be buried in a tumor and left indefinitely as the radon loses its energy at the rate of one-sixth of its value per day.

The institute contains examining rooms, a minor surgery and instruments for diagnosis and treatment of practically all types of cancer. Emphasis is placed on diagnosis, as it is believed no patient can be properly treated for a cancer unless the exact type of the cancer is known. To facilitate diagnosis, biopsies or small fragments of the tumor are subjected to microscopic examination by a competent pathologist. Complete records are kept on all patients treated.

A library of major current medical journals affords the personnel and visiting physicians up-to-date material and acquaintance with forms and results of treatment in other institutions. Equally important is a photographic department with which a graphic record may be made of a visible tumor before and after treatment.

Business Office Essentials

By A. M. McCARTHY, M.D.

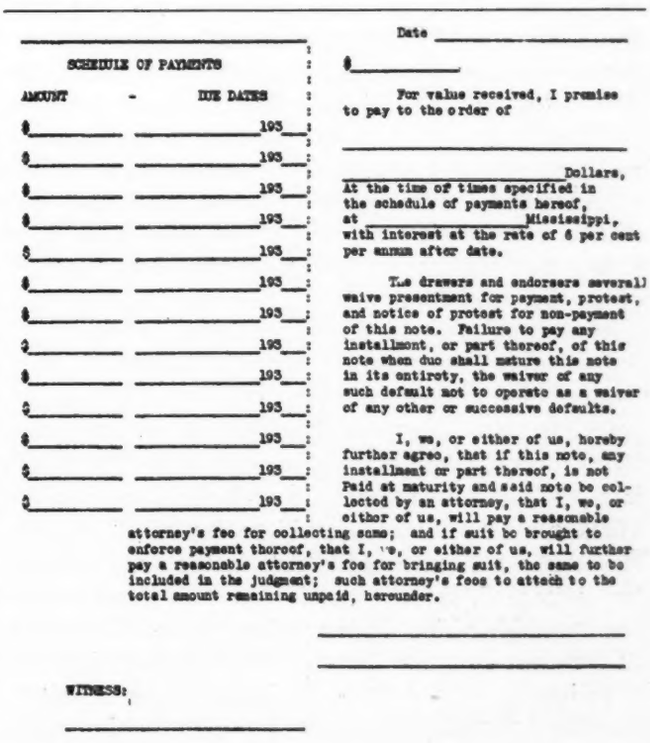
A COMPETENT business manager is a requirement of every hospital, irrespective of size, and to attempt to do without one is false economy. Especially is this true in the physician-owned hospital. With a capable business manager the organization of the business office in a small hospital is comparatively simple because functions of this office usually can be relegated to one person. A quiet, dignified, private office with an adequate communication system, easily accessible to the public, the clerical office of the lobby and the receiving room, is a necessity for a business manager. Full authority to execute the business policies and responsibility only to the owner, administrator or board of trustees, as the case may be, is essential. An informed business manager will organize details according to recognized standards and keep ahead in methods of bookkeeping and office routine.

With small hospitals the major problem is not one of organization but the selection and training of the individual. Because of the economic status of most small hospitals, the individual adaptable to this training must be selected from the group whose earning capacity would not be expected to exceed $2,400 a year. Because business managers are constantly dealing with sick people and anxious relatives, it is desirable that they have a medical background. They should be of the executive type, possess discretion and maturity of judgment, quiet dignity, a pleasant manner and an inexhaustible supply of patience. Graduate nurses with experience in executive management, when given additional training in hospital business methods, are often suited to this work.

It is in this field of education that larger and more progressive hospitals can aid smaller institutions by selection and training of this specialized type of hospital personnel. Opportunity is afforded hospitals with university affiliation where departments of business and finance of the university, plus the efficient business office of the hospital, offer all the educational facilities desirable.

The admission of patients is an important duty of the business office for the first impression made on the patient, his relatives and friends may be the predominating one. The admission of every case is an individual problem. Filling in the admission record is about the only routine part of the procedure. This record should be sufficiently comprehensive to serve as a reference for future requirements. Besides the customary statistical information it should give a resumé of the patient's social, economic and financial status and any previous contact with the hospital and the attending physician. In traumatic, homicidal or suicidal cases which are likely to involve the interest of a coroner or police authorities, it should include a summary of facts surrounding the incident, with the names and addresses of the persons involved. Attached to this record should be a statement of the financial agreement, including rate per day, cost of extras and terms of payment. Critically ill patients should not be unduly disturbed by direct questioning. If they are brought to the hospital without relatives or a financial sponsor, the making of this record must be postponed.

When practical, all information should be obtained in privacy. Every effort should be made



Date _____

$_____

SCHEDULE OF PAYMENTS

AMOUNT - DUE DATES

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For value received, I promise to pay to the order of

_____

_____ Dollars, At the time of times specified in the schedule of payments hereof, at _____ Mississippi, with interest at the rate of 6 per cent per annum after date.

The drawers and endorsers severally waive presentment for payment, protest, and notice of protest for non-payment of this note. Failure to pay any installment, or part thereof, of this note when due shall mature this note in its entirety, the waiver of any such default not to operate as a waiver of any other or successive defaults.

I, we, or either of us, hereby further agree, that if this note, any installment or part thereof, is not Paid at maturity and said note be collected by an attorney, that I, we, or either of us, will pay a reasonable attorney's fee for collecting same; and if suit be brought to enforce payment thereof, that I, we, or either of us, will further pay a reasonable attorney's fee for bringing suit, the same to be included in the judgment; such attorney's fees to attach to the total amount remaining unpaid, hereunder.

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WITNESS:

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by the admitting officer to use dispatch, kindness diplomacy and tact, in handling details. It is the duty of the business office to care for the valuables and money of the patients admitted. Every patient should be informed that the hospital cannot be held responsible for valuables and money unless they are deposited with the business office and a receipt is issued. Valuables and money of an unconscious patient should be itemized and witnessed before being received.

Fixing of fees is a much discussed and disputed subject. The flat, all-inclusive rate, for hospital service is growing in popularity. This method distributes the cost of special services among all patients irrespective of the use of these services by the individual patient. There are several advantages in this system. There is economy in simplifying business management. Second, the patient knows exactly what the cost of hospitalization is going to be for a given number of days. Third, the attending physician is able to tell the patient the exact daily cost in his initial discussion of financial arrangements. Fourth, it promotes good will for the institution by abolishing misunderstandings concerning fees. Any hospital attempting to introduce this scheme must be prepared for an appreciable increase in the use of its special services. This, however, may not be so much of a disadvantage as at first appears.

Effective Collection Methods

The ideal method of handling collections is to have all bills paid by the time the patient is discharged from the hospital. Difficulties are encountered in carrying out such a program completely, but hospitals avoid piling up considerable expense in collecting accounts and build up good will for the institution by this method.

When a patient is admitted a complete plan of payment should be made which calls for a weekly advance payment for routine service, and cash for special services as received. Every hospital has a few patrons known to be reliable and capable of paying accounts in full when discharged, and with them such a requirement is unnecessary.

One of the important factors in successful collection of hospital accounts is a definite understanding with the patient, or the person responsible for payment of the account, at the time of admission. The room rate and the charges for various extra services should be explained, and if the length of the patient's stay in the hospital can be estimated, it is a good plan to estimate the amount of the bill. If the patient is unable to pay in advance or raise the estimated amount by the time he is ready to leave the hospital the business manager should make arrangements for deferred payments. In every case deferred payments should be acknowledged by a legal note, signed by the patient and the next responsible person if the patient should die. Endorsement by another financially responsible person is desirable so that recourse can be had on the third party if the estate is insufficient to meet the payment. This note legally acknowledges the debt and can be fortified by attached mortgage or trust deed on personal property or life insurance.

How Banks Handle Notes

If it is necessary for a patient to extend his payments over a prolonged period, the hospital may negotiate such a note with a local bank, and receive payment of the account when the money is needed. Banks handle notes in three ways:

1. Without recourse. If the note, as it is drawn, is satisfactory to the bank the bank buys the note from the hospital, assumes all responsibility for collecting it and cannot come back to the hospital for recourse if the note is not paid. With the present low interest rates and scarcity of good loans, banks often appreciate obtaining this business as the bank makes the interest.

2. With recourse. If the note as drawn is not entirely satisfactory to the bank, the bank will advance payment only over the endorsement of the hospital. If the bank is successful in collecting payment, it earns the interest; if collection is not made the hospital must refund the advance payment, plus interest.

3. As collection items. The hospital merely leaves the note at the bank and the bank issues a collection receipt for it. No money is passed. If and when the note is paid, the hospital's account is credited with the amount of the note plus the interest, less a small fee for handling. The bank notifies the maker of the note that it holds the note and expects him to pay it at the bank. The maker need not know that the bank does not own the note and this procedure often has a stimulating effect on deliquent payments.

A well managed hospital should have a good banking connection. The business manager can gain knowledge and assistance through a cooperative bank. When credit is necessary the bank can be consulted regarding signatures that will be acceptable on a note, and if the banker suggests a mortgage on collateral of some kind, the business manager can be prepared to ask for it and have the necessary forms to be signed. A good bank can give a hospital all this service and provide a more profitable and congenial relationship than a collection agency.[1]

[1]Read at the Southeastern Hospital Conference, Atlanta, Ga., April 10, 1937.

Turns With a Supervisor

In whose hands may often rest the surgical patient's safety

By JOSEPH C. DOANE, M.D.

THE nursing set-up of the average surgical department consists of one or more supervisors; one or more head nurses; pupil nurses; orderlies, and ward maids. The surgical supervisor serves as the executive officer of the department—a small, specialized and complicated organization built within the institution.

She is expected to do much administrative work. She spends much time compiling reports relative to subjects such as nurse assignments, hours on and off duty, infections, hemorrhages, approving slips, certifying as to proper preparation for operation, requisitioning supplies and attending to myriads of other details. She may have under her direction several floors with two or three scores of patients on each. Nurses responsible to her may number a score or more. Ward maids, orderlies and even porters and cleaners look to her for direction and discipline. Withal she must present her department in orderly condition each morning at nine o'clock for round making.

Not the least of the demands upon her tact and understanding relate to her contacts with visiting surgeons and their assistants. Most surgeons are appreciative of a calm, efficient surgical supervisor. Others adopt a carping, fault-finding attitude.

Let us glance now at the duties which confront the supervisor as she reports at 7 a.m. for her day's work. To most average hospital executives, the supervisor's morning and evening reports are but a name. It would enlighten them if they could attend a conference and learn just what constitutes these twice daily reports. In reality they consist of the transference of responsibility for every patient in the surgical department from the night staff to the day staff, and in turn eight or twelve hours later from the day staff to the night staff.

Matters representing the usual and unusual happenings of the day make up the bulk of the report. A rising pulse or a climbing fever, the development of delirium which may indicate the likelihood of a patient wandering from his bed and becoming injured, a permission given by the director for extra nursing, the visit of a fault-finding or overanxious relative, a special tray or treatment preparation for the following day, the securing of consent for operation when relatives visit during the evening, a general comment on the mental and physical condition of all patients are some of the interesting matters discussed by the retiring day supervisor and her staff with the oncoming night group. The omission of comments relative to a hemorrhage, an infection, a failing heart or an oncoming delirium may result in the loss of a patient's life. Only the alert nurse serves as a liaison officer between the patient and the physician.

The supervisor of experience gains an almost uncanny ability to foresee untoward events in each patient's case. Years of experience have taught her to sense the presence of hemorrhage in postoperative cases, the meaning of blanching lips, sighing respiration, rising pulse and falling blood pressure. An obtuse careless nurse who having eyes and an R.N. fails to use the former or to interpret what she sees in the light of the experience represented by the latter has no place in the surgical department. Except perhaps in the maternity department there is no place where alertness, intelligence, tact and that sixth nursing sense pay higher premiums than in the surgical department.

The orderly approach to an operation demands first that a reservation be made in the operating department. This s c h e d u l i n g of operations possesses more possibilities for trouble than appear at first sight. No preparation of the patient can be undertaken until the hour and date have been discovered at which the operating room is available. Delay in scheduling operations often makes necessary the preparation of a patient far into the night.

It is unfair both to the patient and to the nurse

to give enemas and shave abdomens late in the evening prior to an operation, when the patient should be allowed to rest. Thoughtless visiting surgeons and surgical residents often fail to notify surgical supervisors of their plans early in the day previous to operation in order that these preparations may be performed thoroughly and without haste.

Only in an emergency have these procedures any place in the surgical ward after 7 p.m. on the day previous to surgical treatment. A thoroughly worked out procedure of reserving operating room time is a basic requirement for every well run hospital. Priority of appointment to service in the hospital should be recognized whenever complications as to time arise.

An important step is the securing of a signed permission for operation. Indeed, in some hospitals the scheduling of an operation is not permitted until a consent has been signed and filed. In order to prevent an anesthetic being started before a permission has been secured, the supervisor is often made the first check on its presence, she not being permitted to begin the preparation of the patient until she is sure that this consent has been executed. The chief resident physician is made the second check and finally the operating supervisor is directed not to permit an anesthetic to be given until she has personally observed the stamp on the chart certifying that the consent form is in the hands of the proper person.

Preparing for an Operation

The operation having been scheduled, the preparation of the patient is the next step. In some hospitals a flying squad of nurses attached to the operating clinic visits each ward and prepares patients for surgical treatment. This plan has its merits which consist chiefly of development of unusual skill and speed in performing this work and of assurance that there will be no interruption while it is going on. In the majority of hospitals the patient having been prepared by the nurses of the surgical department is presented to the operating clinic ready for the attention of the surgeon.

When the operation is an emergency the preparation of the operative field is frequently performed on the operating table. It is far better that this should be done than to have unusual delay, with resulting irritation on the part of the surgeon and his assistants and with the confusion and likelihood of mistakes that accompany haste. Thirty minutes wait at 2 a.m. seems an interminable time.

The preparation for an elective operation is a complicated affair for each step of which the supervisor is responsible. A final inspection of each patient before he leaves for the operating room is her responsibility or that of a department head nurse to whom this duty has been assigned. Preoperative preparation as it affects the nurse has been largely standardized. This certainly cannot be said in regard to the preoperative dressings and skin treatments directed by the surgeon. Little reason seems to underly this great diversity of preoperative technique.

Technique Too Varied

Someone has remarked that surgeons appear to resent standardization of preoperative, operative and postoperative technique because being different renders them distinctive. This is probably not the opinion of most seasoned and experienced surgeons although a tendency to variation in such unimportant matters as the strength of mercurochrome or other solutions is continually noted.

It is not pertinent to this article to discuss the extent of shaving, scrubbing and sterile dressing application necessary for the head, shoulder, chest, gall bladder, stomach, intestines, and other operative fields. It is better to prepare too widely the field about the area to be incised by the surgeon than too narrowly.

There are, however, certain specific things for which the surgical supervisor is held responsible prior to the departure of the patient from her ward. She must see that the chart is completed and that it accompanies the patient to the clinic. The official stamp certifying permission for operation, a record of urinalysis within twenty-four hours, a complete history with record of heart and lung examination, recorded temperature, pulse and respiration up to the hour of leaving the ward, a final checking of all orders for preparation, the record of the clergyman's visit if the patient desires to see one, and a slip of paper upon which the time of the last urination and the quantity voided are set down, are details for which the supervisor is responsible.

Some believe that a tonsorial course should be given in each hospital. All nurses are not good barbers and the field shaved sometimes suggests the skin of a battle-scarred veteran. Sometimes the fault may be attributed to poor shaving equipment. Again haste may be the cause, but usually it is lack of proper instruction. At any rate, sufficient time should be given so that dry shaving will not be necessary. An unskilled pupil nurse should not be permitted to shave an operative field before she has given evidence of being competent.

Some executives have not considered the im-

portance of a properly prepared surgical stretcher. Nursing technique books devote not a little space to the matter of preparing surgical stretchers, ether beds and ordinary beds. The stretcher should be first of all safe, not easily upset and its linen and blankets should be ample so that the patient presents a tidy appearance en route and is properly protected against cold and draughts.

All being in readiness the patient is placed upon the stretcher a few minutes before the time at which a call is expected from the clinic requesting the patient. Such an apparently little matter as allowing a patient to remain for some time on a stretcher within the confines of the operating clinic so that the surgeon may not be delayed is capable of much harm to the apprehensive individual.

The patient's transfer to the operating clinic should be marked by the avoidance of disturbing sights, sounds and smells which add to his terror.

Now that the patient has left the surgical department, the supervisor oversees the continuance of the work of the day such as feedings, bathings, bedpan hour, dressings and the preparation of other patients. On operating day, it must appear to her, that a continual stream of responsibility leaves and enters the surgical department all day long. The operation ward must be prepared for the return of patients, ether beds properly made and warmed, adequate solutions and solution equipment at hand and everything must be in readiness to meet an emergency upon the return of the patient. When the patient is brought back the uninitiated cannot fail to remark the dexterity with which the patient is removed from the stretcher and placed in the prepared ether bed.

Watchful Waiting

Certain general rules now become applicable for which the supervisor is responsible. The patient is never left alone until he has completely recovered consciousness. The mouth must be kept clear of mucus. In case of vomiting the nurse must take precautions to prevent the entrance of foreign material into the trachea. The color of the face, the character of the breathing, the prevention of the obstruction of breathing by a "swallowed tongue" are matters which it would seem might be taken for granted and yet which constitute subjects for drill and redrill by this supervisor of younger nurses.

It need not be remarked that one of the mistakes the supervisor must avoid is to allow artificial dentures to remain in the patient's mouth as he leaves for the operating room. Anesthetists shrug their shoulders at the inefficiency of nurses when this occurs. If spinal anesthesia has been given, proper elevation or depression of the head of the bed is important. The recording of pulse and respiration rates every fifteen minutes and of temperature readings every half-hour until the patient has fully recovered from the anesthetic; when consciousness completely returns the toilet of face, body and back; in an uncomplicated case the application of a dry gown and dry blankets, all are important to the patient's welfare.

On the Alert

The bedside nurse is alert to the appearance of dressing staining indicating hemorrhage, to proper ventilation of the ward, to notification of the physician when the pulse rises or other signs of shock or collapse appear, to meticulous adherence to the doctor's orders as to the position of the patient, to inspection of drainage and to charting of developments in the case.

In clean cases the matter of dressings is of little importance and consists largely of the removal of sutures by the surgeon and the changing of dressings as directed by him. A properly equipped dressing cart with sufficient supervision of the dressing nurse by the supervisor, insistence on proper gowning and gloving by doctor and nurse and avoidance of any nursing slip in technique are matters which become almost second nature to the supervisor.

The safety of a patient after operation often rests with surgical nurses. They may be possessed of initiative, good judgment and tact. However, one runs for help when cyanosis from tongue swallowing results. Another pushes forward the jaw and withdraws the tongue and possibly saves the life. One may stand helpless when breathing stops; another may start artificial respiration. One may conclude that the pulse naturally rises from excitement incident to regaining consciousness; another notes the pallor, air hunger and dimness of vision with falling blood pressure and concludes that the patient is bleeding and sends for the physician.

The trained supervisor often distinguishes herself by retaining her composure when others lose theirs. It is she who through years of experience has come to know the odor of acetone, of uremia. She senses in looking down the long row of beds the restlessness of hemorrhage, the signs of delirium. She knows the signs of approaching death and if the intern is not present notifies him so that he may send for relatives or clergyman. She is of much assistance to a visiting staff and often the smoothness of technique in a surgical department suggests the presence somewhere of a highly skilled supervisor.

A Half-Century of Progress

By Mrs. CLYDE E. SHOREY

FIFTY years of continuous service on behalf of the Chicago Presbyterian Hospital is the record of the hospital's woman's board of that institution. When the hospital was opened more than half a century ago the women sewed all linen supplies for the institution by hand. Now the board's activities have expanded to include endowments, hospital supplies, a social service department, scholarships for nurses and a library.

The board membership numbers about 225 and consists principally of committees, representing an average of more than forty churches in the Chicago Presbytery. Forty-five out of this number are exempt from payment of the $2.50 annual dues, because they are on an honorary list or wives of ministers. Life memberships, recently established, are $100 each, nontransferable.

Aside from dues, three committees raise funds for the general budget. When a new member is notified of her election to the board, she is asked to give to the pledge fund or to tag for the hospital. Pledges are secured only from members. Another committee solicits associate memberships from Presbyterian women through the churches. The third committee secures gifts from contributors who are nonmembers of Presbyterian churches but are interested in the hospital for its work in the community.

During the last ten years $25,000 was raised for the nurses' endowment fund, which is outside the general budget. This amount was pledged on the twenty-fifth anniversary of the school and paid in full on the thirtieth anniversary. The final $2,500 was secured through an opera benefit.

In recent years linens have been purchased wholesale by funds given by a Thanksgiving offering. Ten years ago the money raised for linens was invested in a permanent linen fund. Last year $25,000 was turned over to the men's board as an endowment for this fund. During twenty-five years $41,335 has been given by Sunday School children for an endowment for free beds.

Realizing the importance of special care for ward patients who need constant attention and are unable to have it, three women have endowed three and one-half nurses at $35,000 each. Through efforts of alumnae of the school of nursing and the woman's board a fund necessary to provide another nurse is almost completed. With additional donations, six nurses last year gave services totaling 1,540 days and nights. All of these endowment funds have been turned over to the men's board of the hospital.

The women's board, also, has made donations of a housewifely nature to provide articles which would otherwise have to be supplied through the general budget of the men's board. For more than twenty years two hospital dining rooms have been kept completely equipped with silver through collections of soap wrappers. One is for the interns and doctors and the other for special nurses, office workers, laboratory technicians, serving in all 150 persons each noon. Any men's board will appreciate that such equipment kept up continually is quite an item in the general expense. Also the delicacies committee collects annually from 6,000 to 7,000 glasses of jelly for ward patients and from $250 to $300 for fresh fruit. Last year 12,842 articles of hospital supplies, consisting of crib sheets, infants' gowns, electric pad covers, were cut in the hospital workroom, and sewed by the women through the local church organizations.

With the money collected for our general expenses, the woman's board finances the social service department. This was started in 1909 by the board, with one worker and volunteers. Now there are four full-time workers, three of whom are registered social service workers. Last year a car was purchased, funds being secured through the sale of a large doll house presented to the department. Second, the board supports a trained librarian, who distributed 22,000 books to the patients, nurses, interns and employees in 1935. We have a library of 6,000 books and through an affiliation with the public library, any book a patient may wish can be supplied. Third, the board offers three scholarships to nurses going as missionaries and a $100 educational scholarship for postgraduate work.[1]

[1]Read at the meeting of the Tri-State Assembly, Chicago.

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Conducted by John R. Mannix and R. C. Buerki, M.D.

Operating a Central Supply Service

By Sister M. Margaritas

Efficiency, economy, accuracy—St. Elizabeth's Hospital, Chicago, has achieved these for four years by means of a central supply service

A HOSPITAL equipped with a central supply service department is making a 100 per cent effort to render efficient service to its patients and attending staff.

Through such a centralized or special department all orders for treatments, such as enemas, catheterization, douches, intravenous injections, hypodermoclysis, all dressings of wounds, irrigations of all types, light treatments, and hot packs are administered. General obstetric treatments are not included in this service.

A central supply service station ensures to patients better and more prompt service, and is also beneficial from an economic point of view.

We are certain that we receive more satisfactory service from nurses specifically assigned to this work, who are in a position to concentrate solely upon the administration of treatments. Frequently floor nurses are too much occupied by being required to care for both patients and emergencies, or seriously ill patients. It is then probable that treatments will be given irregularly. A central service station properly managed permits no excuse for neglecting the patient.

Central service eliminates waste of time and supplies. Nevertheless, every patient receives the required quantity and the best quality and is given service at a specific time. Since one individual is responsible for the equipment and supplies, instruments are kept in better condition, are less often broken or misplaced and the waste dressing material is kept down to the minimum. It is also possible to reduce the quantity of special equipment in circulation. When every floor is responsible for equipment, no one accepts the responsibility for negligence.

The central service department is conducted by a supervisor whose sole objective is to give satisfactory service to doctors and patients, by carefully instructing the students and by conscientiously supervising their work. The supervisor interested in her department will endeavor to maintain the equipment in excellent condition, and also make an effort to obtain up-to-date and the best possible supplies.

A central supply service should be located in the center of the hospital, so that it will be equidistant from the various floors. It is important to have ample space for the large quantity of supplies. Trays should be well equipped with all supplies that might be used by the doctors in the administration of treatments.

A notation must be attached to every incomplete tray, so that when a call is received for the treatment the nurse will know how to complete the tray without unnecessary delay.

Setting Up Trays

Trays should be so furnished that when a doctor orders, for example, a venesection for an ambulance case entering the hospital, it will be possible to have the tray in the room by the time the doctor is ready to proceed. Trays for similar treatments should be placed close together. For example, one cupboard should contain all the trays for gastric lavages, gastric gavages, continuous gastric aspiration, Ewald aspiration, transduodenal lavages, and set-ups for closed drainage of gall bladder. This arrangement will give more satisfactory service to the doctors.

Each doctor's preferences should be noted in order to give efficient service. Any instrument, special tray or personal article is also kept here, in readiness for him.

Every morning before eight o'clock, assistant supervisors of floors recheck physicians' orders and send a written slip of the various treatments to be carried out to the central supply service department. Later orders may be given by telephone, with the exception of medications. The order chart must be brought to the supply room in this case. The supervisor of central supply service should assign treatments to nurses according to the type of treatment and experience of the nurse. The nurse who is to give the treatment copies the order on an order blank, takes it to the respective floor, and rechecks with the supervisor before the treatment is given. This is done in order to avoid errors.

Close Supervision Needed

During the administration of treatments students should be closely supervised by the instructress of nurses or the assistant supervisor of central supply service. After the treatment has been given, the nurse giving it should chart the treatment and sign her full name. The nurses on the floors should be notified to observe the treatment and discontinue it and return supplies to the proper place at once. For instance, a nurse from central service is sent to start an intravenoclysis. Before she goes to the patient's room the order is rechecked with the supervisor. The treatment is begun and charted by the nurse from the central supply service department. After charting the treatment it is reported to the nurse in charge. The nurse on the floor watches the treatment and discontinues it, and returns the tray to the supply room.

The floor supervisors should supervise students while the treatments are being given.

Records of all orders, including the signature of the nurse giving the order and the signature of the nurse administering the treatment, are kept from twenty-four to thirty-six hours, to recheck any error or to investigate any complaint.

To administer all treatments from the central supply service department between the hours of 7 a.m. to 9 p.m., in a hospital of 200 surgical and medical patients, eight student nurses are required on day duty. One night nurse can manage a department if treatments are carried out on the respective floors. Eight nurses should be taken from the freshmen, junior and senior classes in order that the service may not be interrupted when any one of the groups is attending class. Freshmen are permitted to assist only with minor treatments, such as, giving enemas, catheterizations, douches, assisting the doctors or interns with the dressing of wounds, irrigation of wounds, and assisting the doctor in giving hypodermoclysis and intravenoclysis. Other students are given more responsible work. Senior nurses should be permitted to assist with thoracentesis, paracentesis, venesections, and spinal punctures under supervision.

A nurse during her training spends at least twenty weeks in this department under careful supervision. Every nurse keeps accurate record of all treatments she has given while serving in this department. When the nurse leaves the central supply service department the record is given to the supervisor in charge, who in turn records each record and presents it to the superintendent of nurses for permanent recording.

Many people ask whether the interest of the nurse is held by the particular patients. Does the nurse really follow up the case as she should? It has been found that the nurse takes more interest in the patients, and watches their recovery more carefully. She knows the condition of many patients instead of just a few, and she has the opportunity of observing more varied cases.

Excepting extreme emergency items such as drugs, any supplies may be kept in central supply service. The only drugs that should be kept in central service are those used in the administration of treatments such as paraldehyde and chloral hydrate for retention enemas, novocain and cocaine for anesthesia, ephedrine, menthol, tincture of benzoin, argyrol and all antiseptics.

Medications used in the administration of treatments should be kept in this department to prevent possible delay in the giving of treatments caused by inability to secure the drug. This provision is a great saving and help to patients receiving the treatments only once. Any drug used for several treatments should be ordered from the main drug room for the individual patient.

A supply of instruments to be used in emergencies should be kept in central supply service. Trays for giving the enemas, douches, male and female catheterizations, bladder irrigations, trays for the irrigation of wounds, dressing of wounds, the application of all dry and hot fomentations, nasal packing, intravenous hypodermoclysis, all examination trays, spinal puncture, venesection, paracentesis, thoracentesis, and trays for hemorrhaging tonsils should also be kept in central supply service. Baumanometers and stethoscopes, however, should not be kept in this department unless the floors cannot be supplied with individual apparatus.

It is absolutely essential for oxygen to be kept in central supply service because delay might prove fatal. The few moments necessary to deliver oxygen from central service would not necessarily jeopardize the patient.

To maintain efficiency a twenty-four hour service must be maintained for it is important that someone assume responsibility for the distribution of supplies during the night also. If the department were left without supervision, equipment might be misplaced, causing confusion and the delaying of service.[1]

[1]Read at the meeting of the Tri-State Assembly, Chicago, May, 1937.

Observations on the Action of Potassium Mercuric Iodide

By E. E. Ecker, Ph.D., F. Havorka, Ph.D., and R. Smith, M.A.

IT IS common practice to keep hand brushes in 1:5000 solution of potassium mercuric iodide in jars. The solution is changed at intervals of about 12 hours and between these changes jars and brushes are washed separately with soap and water.

In spite of the fact that this concentration of the disinfectant is strongly bactericidal, bacteriologic examination of 107 jars yielded positive cultures in 86. Gram-negative bacilli and gram-positive cocci were found but the most common organism was a green producing organism of the Pseudomonas group. Nevertheless, the same solution (1:5000) can kill the Pseudomonas.

The present study was undertaken in order to explain the discrepancy, which as will be seen is due to a too small number of HgI_2 ions per unit of solution when applied to organisms dried on various surfaces.

A study of time-killing concentration of potassium mercuric iodide was made for periods varying from 5 minutes to 3 hours. As test object the Pseudomonas was employed. A 1:5000 solution readily destroyed the organism in a period of 5 minutes. Similarly, the solution destroyed both Staphylococci and Esch. coli in a period of 15 minutes. Solutions from the contaminated jars filtered through paper also destroyed the Pseudomonas.

When two brushes were placed in a jar containing 500 cc. of a 1:5000 solution of the mercurial and allowed to stand for 24 hours at room temperature the solution retained unimpaired its germicidal qualities toward this organism. Solutions of the mercurial were then made with and without sodium carbonate or dye.

In addition to these variants the factor of distilled *versus* tap water was also investigated but the mercurial retained its potency. Twenty-five men washed their hands in the 1:5000 solution and a test of the filtered solution showed that the Pseudomonas was killed in a period of 30 minutes, a slight reduction in killing potency. It was also noted that solutions made of pigmented tablets would eventually lose their pink color but this change did not affect the potency of the germicide.

Experiments Were Made

The reason for the persistence of the Pseudomonas in the solution was then sought on the assumption that the germicide might not destroy the organisms fixed to surfaces. Tinker and Sutton[1] have shown that organisms dried on rubber strips were not destroyed by various antiseptic and germicidal agents. They concluded "that iodine, trinitrophenol, Harrington's mercuric chloride, mercurochrome 220 and potassium mercuric iodide will not kill most of the resistant and some of the less resistant pathogens under conditions of perfect contact."

Accordingly, pieces of rubber, silk, metal, glass, hair, gauze, paper and wood were autoclaved at 240° F. for 15 minutes. These pieces were then placed in Petri dishes (four articles in one dish and ten pieces of each article). The materials were contaminated with 2 c.c. of a 24-hour culture of the Pseudomonas. The pieces were then taken out and dried for 18 hours at 37° C. In order adequately to expose the materials to the germicide, 50 c.c. was poured into a Petri dish so as completely to cover the materials.

When different dilutions of the mercurial were employed, surfaces for each dilution were separately prepared. Then at time intervals of from 5 minutes to 5 hours pieces were removed with sterile forceps, washed thoroughly in normal saline (each piece was separately washed) and dropped into 10 c.c. of standard broth. The tubes were kept for five days at room temperature. Rubber, gauze, paper, wood and glass were all cut in sizes of about 1 cm. square. Hair and suturing silk were cut in lengths of 1 cm. and Mitchel skin clips were used as metal objects. As controls the various contaminated surfaces were dropped under aseptic precautions into standard broth.

Table I shows the results secured with a 1:5000 solution of potassium mercuric iodide. (Test organism: Pseudomonas.)

From these results it is seen that the

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TABLE I

Time	Rubber	Silk	Metal	Glass	Hair	Gauze	Paper	Wood
5 minutes	+	—	—	+	+	+	+	+
15 "	+	—	—	+	+	+	+	+
30 "	+	—	—	+	+	+	+	+
1 hour	+	—	—	+	+	+	+	+
2 hours	+	—	—	+	+	+	+	+
3 "	+	—	—	+	+	+	+	+
4 "	+	—	—	+	+	+	+	+
5 "	+	—	—	+	+	+	+	+

+ growth
— no growth

Pseudomonas when dried on rubber, glass, hair, gauze, paper and wood survived exposure to the mercurial. On silk and metal, however, the organisms were killed in about 5 minutes. A 1:5000 solution of bichloride of mercury destroyed the organisms on all the surfaces except wood. The chemical complexity of wood must evidently be responsible for this loss of bactericidal power.

When wood and rubber were soaked in a 1:5000 solution of merphenyl nitrate, bichloride of mercury or metaphen, dried for 24 hours and then inoculated with the Pseudomonas, the wood did not inhibit the effect of these mercurials. This, however, was not the case with potassium mercuric iodide. Mercuric oxycyanide treated wood required one hour's exposure to mercuric oxycyanide 1:5000 to destroy the Pseudomonas, and merthiolate treated wood required two hours' exposure to merthiolate 1:5000.

An increase in concentration of merthiolate is more effective. Thus, if wood or rubber be treated with merthiolate (1:1000) then contaminated with the Pseudomonas and exposed again to merthiolate (1:1000) the organisms are killed in 5 minutes. Merthiolate (1:5000) destroyed the organism dried on hair in a period of 30 minutes, on silk, 2 hours, on paper and glass, 4 hours. A 1:1000 dilution of merthiolate readily destroyed the organisms (5 minutes) on hair, silk, paper and glass. Pyridyl mercuric chloride did not kill the organisms on wood but on rubber it did so in about 2 hours.

Hog bristles as found on toothbrushes readily absorb the merphenyl salts rendering them self-sterilizing.

Mercuric oxycyanide (1:1000) did not readily destroy the Pseudomonas on rubber or wood. Mercurochrome (1:1000) failed entirely on hair, rubber and wood.

In order to obtain more information on the failure of potassium mercuric iodide to operate on surfaces, a study of its dissociation values was made.

A Leeds and Northrup Kohlrausch bridge with helical slide wire and extension coils was used as a means of securing variable ratio arms. Both the instrument and the coils were of the type shown to have no inductance errors. The balance point was detected by a telephone using two stage amplification. No difficulty was experienced due to the oscillation of the amplifier. The cell used was of borosilicate glass and was made after the design of Hartley and Barrett[2]. The electrodes were coated with a medium layer of platinum black and ignited to redness. This gave a coating of dull gray.

C.P. potassium iodide and C.P. mercuric iodide were used in making all of the solutions. The 2 per cent solutions were used in preparing 1 per cent solutions and these in turn were diluted in making 0.5 per cent solutions.

The cell constant value was determined before and after each series of runs and no variation greater than the experimental error could be noted.

The resistances of the solutions were checked by several different bridge settings and the averages of these readings were taken. The usual precautions characteristic of accurate conductivity measurements were taken. Two independent sets of determinations were made for each concentration and the averages of these are recorded in Table II.

The conductivity curve is found on the accompanying graph. From these measurements it is evident that potassium mercuric iodide is ionized to a considerable extent at normal dilutions. Even in a 2 per cent solution the compound is fairly highly ionized. As dilution proceeds dissociation increases but the total number of HgI_2 ions may be less per given unit (1 c.c.) of solution. Potassium mercuric iodide is highly dissociated at a dilution of 1:5000 but the total number of HgI_2 ions per c.c. may be too small to ensure destruction of organisms on surfaces.

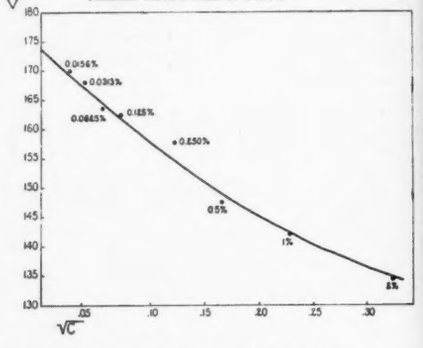
Taking this possibility into consideration we added 1 per cent liquid soap to the 1:5000 solution of potassium mercuric iodide in order to lower the surface tension of the liquid and to increase the number of HgI_2 ions in the surface films. This increase in concentration of the solution in the surface film follows according to the Gibbs absorption equation:

$$u = \frac{C}{RT} \times \frac{dy}{dc}.^*$$

Table III shows the effect of 1 per cent liquid soap on the action of potassium mercuric iodide (1:5000). (Test organism: Pseudomonas.)

The addition of soap has, as assumed, markedly increased the activity of the mercurial except on wood. The same holds true for increased concentrations of the mercurial. Concentrations of from 1:100 to 1:3200 will also destroy the Pseudomonas on the various surfaces except wood. An increase of concentration of HgI_2 ions effectively enhances the bactericidal power of potassium mercuric iodide. These observations are of importance in the study of germicidal agents. Phenol coefficients as generally per-

Graph I shows conductivity curve of various concentrations of Potassium mercuric iodide. (Σ = 0.0156%)



formed are not indicative of the value of germicidal agents in actual use.

Solutions of potassium mercuric io-

*u = the excess of solute in the surface layer per sq. cm. of surface.
C = molar concentration per liter.
T = absolute temperature.
Y = surface tension.
R = gas constant.

TABLE II—CONDUCTIVITY OF POTASSIUM IODIDE AND MERCURIC IODIDE MIXTURES.*

Per Cent of Concentration	c	I	y
2.000	0.3229	0.01406	134.5
1.000	0.2283	0.00742	142.0
0.500	0.1615	0.00386	147.5
0.250	0.1271	0.00199	158.0
0.125	0.0792	0.00103	162.4
0.0625	0.0560	0.00053	163.5
0.0313	0.0396	0.00028	167.9
0.0156	0.0281	0.00015	169.8

*c is the sum of the two equivalent concentrations of the two salts, I is the specific conductivity of the salts after the usual solvent correction was made, and y is the equivalent conductivity.

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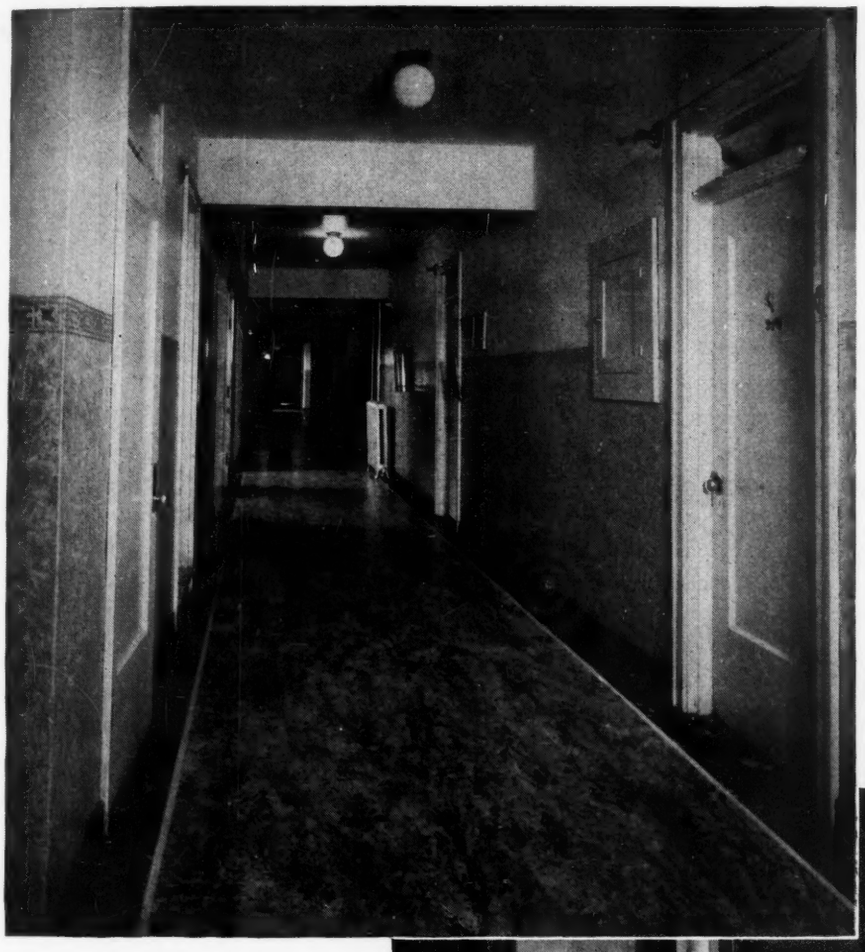

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TABLE III

Time	Rubber	Silk	Metal	Glass	Hair	Gauze	Paper	Wood
5 minutes	—	—	—	—	—	—	—	+
15 "	—	—	—	—	—	—	—	+
30 "	—	—	—	—	—	—	—	+
1 hour	—	—	—	—	—	—	—	+
2 hours	—	—	—	—	—	—	—	+
3 "	—	—	—	—	—	—	—	+
4 "	—	—	—	—	—	—	—	+
5 "	—	—	—	—	—	—	—	+

dide 1:5000 as commonly used in hand brush jars in hospitals often contain micro-organisms. An organism of the Pseudomonas group was isolated from these jars. When the organism was suspended in a 1:5000 solution of potassium mercuric iodide it was readily destroyed. This discrepancy was eventually explained by the fact that the same organism dried on various surfaces like rubber, glass, hair, gauze, paper and wood was not killed by the 1:5000 solution of the germicide.

Potassium mercuric iodide was found to be highly dissociated in a 1:5000 solution but there were not enough HgI_2 ions per unit of solution to destroy the organisms dried on surfaces. Incorporation of 1 per cent liquid soap to the 1:5000 solution concentrated the HgI_2 ions in the surface film thus enhancing the bactericidal value of the germicide. The same held true for greater concentrations of mercurial.

When the Pseudomonas was dried on wood, the addition of 1 per cent soap or increased concentrations up to 1:50 of potassium mercuric iodide failed to kill the organism. In order to overcome this difficulty wood was treated with merphenyl nitrate 1:1500-5000, bichloride of mercury 1:1000-5000, metaphen 1:2500 or merthiolate 1:1000.

These observations are of importance in the study of mercurials and other germicides in common use. Phenol coefficient determinations as usually performed do not give a true indication of the value of a germicide in actual use. Organisms dried on various surfaces should also be exposed to the germicides in order to test practical effectiveness.

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[1] Tinker, M. B., Sutton, H. B.: J. A. M. A., 87: 1347, 1926.

[2] Hartley, H. and Barrett, W. H.: J. Chem. Soc., 103: Pt I, 786, 1913.

New Dial System Saves Money

By William O. Rice, M.D.

BECAUSE of expansion of facilities at Rhode Island Hospital, Providence, R. I., which brought an increasing load on the telephone system, a new intercommunicating dial system was installed and went into operation in June, 1936. This change was made upon the recommendation of the telephone company, who promised more efficient service, especially for internal communications, which is two-thirds of our telephone load, and economy, in that we could dispense with two operators. Both of these statements have proved to be true.

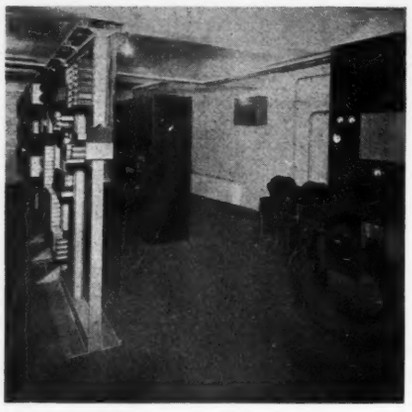
A new three-position switchboard was installed and an information desk at one end. There are nearly 300 stations throughout the hospital buildings which necessitated only two positions of the board being used. On the wall in this room is a cabinet showing what doctors are checked in which is a part of our "in and out" system. On the information desk is an index of patients and the latest report on the condition of those in the private pavilion. On this desk is also a transmitter for our paging system.

Two operators handle the thirteen trunk lines for incoming and outgoing calls. All inquiries in regard to the condition of patients are turned over to the information girl, who has more time to answer them intelligently. This girl also handles all paging calls which go out over fifty stations throughout the buildings.

At each dial telephone there is a directory for the internal communicating stations. If anyone wishes a person paged, the information girl is dialed and the message given to her. The person hearing his name called, immediately dials this girl at the nearest telephone and receives his message. If a nurse wants an intern on a certain ward in an emergency, the information girl pages as follows: "Dr. John Doe—Ward A." The intern hearing this call over the paging system goes at once to the ward.

Outside calls are not allowed from any of the wards, but they are allowed for hospital business from heads of departments. In such a case "O" is dialed and the number given to the operator, she in turn asks the

Two operators and an information girl comprise the staff. The elaborate equipment is installed in a clean, dry room, with a linoleum floor and no pipes running through it.



number of the extension making the call and at the end of the day submits these outside calls to the bookkeeper's office. When patients in the private pavilion call outside numbers, their room number must be given at the same time and these are also turned in each day. Pay telephones are scattered throughout the buildings for the use of employees and visitors.

Elaborate mechanical equipment is necessary for this dial system and it must be installed in a suitable room, which can be kept clean, is absolutely dry, has a linoleum floor and has no water or steam pipes running through it. Fortunately such a room was available at Rhode Island Hospital, after a few minor changes were made. Its size is: 14 feet wide, 28 feet long and 10 feet 6 inches high.

The monthly rental on this new dial system is higher than before, but a considerable saving is made because two operators have been dropped, and the system relieves the operators of a tremendous load.

RUBBER GLOVES...and SOAP

IT'S true, in a physical sense of the word, that rubber gloves and soap are only "little things." But there's no doubt that both play a mighty important part in patient care!

You know how essential it is that the members of your staff be supplied with only the best, the most reliable gloves to protect themselves and your patients against infection. But do you realize how extremely important it is that only the finest, *safest* soap be used in bathing your patients? In fact, the *right* soap has a lot to do with their comfort.

That's why so many leading hospitals choose Palmolive. Made with a special blend of Olive and Palm Oils, Palmolive is bland, non-irritating . . . free from adulterants or animal fats. And, it lathers freely in warm or cold, hard or soft water.

You'll find that your patients actually prefer Palmolive, too. That's proved by the fact that more of them buy Palmolive for their own homes than any other toilet soap!

Palmolive's Extra Quality Is Free!

Although Palmolive *is* a superior quality soap, it actually costs you no more than many less-favored brands.

Your C.P.P. representative will gladly give you prices on Palmolive Soap—and on the finest, most economical soaps for laundry and maintenance use. Ask him, or write direct to Colgate-Palmolive-Peet Co., Industrial Dept., 105 Hudson St., Jersey City, N. J., for the valuable Free Booklet: "Hospital Housekeeping and Cleanliness." It's a dependable buying guide for every hospital soap requirement. Send for your copy—TODAY!

Palmolive Soap

CHOSEN EXCLUSIVELY FOR THE DIONNE QUINS BY DR. DAFOE

Just a Stepchild

By Alta LaBelle

The housekeeping department is the forgotten division of the hospital when construction plans are being made

TO emphasize the relative importance of the housekeeping department to other departments in a hospital, let me quote "hospital dollar" figures previously published. Full personnel expenditure ratios are not itemized; only major salary ratios are given:

135-Bed Hospital	
Nursing School	.1533
Dietary Department	.0473
Housekeeping Department	.0800
225-Bed Hospital	
Nursing School	.1484
Dietary Department	.0416
Housekeeping Department	.0758
387-Bed Hospital	
Nursing School	.1166
Dietary Department	.1000
Housekeeping Department	.0750

It will be noted that the cost of personnel in hospital housekeeping departments is exceeded probably in only one other hospital department, the nursing school.

When a new hospital unit is to be constructed or reconstructed, is not the director of the nursing school consulted on all of the plans and other minutiæ which will enable her to give more satisfactory and economical service? Is she not consulted on the location of the supervisor's station, floor linen stations, utility room, medicine cabinet, to afford her department top efficiency? Is not the dietary department also consulted as to the arrangement of space so that the dietetic staff too can render the best possible service with a minimum of effort and cost?

It is not to question the logic of these consultations that this article has been written. It is to ask that the director of housekeeping, with the second largest personnel in the hospital and who, in the carrying out of her responsibilities, overlaps both the dietary and nursing divisions, be given the same consideration so that she too may improve service in her department and make her share of the hospital dollar go further.

After visiting many hospitals, hotels and clubs, whose housekeeping problems are fundamentally the same, I was impressed by the following facts:

The housekeeping offices were never centrally located but were hidden in a far corner of the basement or in some other out-of-the-way place. This converted thousands of time-consuming and unnecessarily fatiguing steps into lost efficiency. Housekeeping subdepartments were spread over whatever area could not be utilized for any other purpose.

The linen room was often in one corner which was inadequate for the linen turnover, making necessary improvised working conditions and other subterfuges. Not only was this room inadequate but in nearly all cases it was far removed from the laundry. Furniture storerooms, upholsterer's shop, paint shop, carpenter shop, all were spread over remote sections in the building and in most instances were extremely far apart. Can you conceive of a chair being transported from a basement repair shop to a sixteenth floor refinishing shop? Would you consider this good management? This is not an uncommon practice.

Need Central Location

These are only some of the many time consuming jobs occurring under such working conditions and charged to lessened "housekeeping dollar" efficiency. How much more economical and logical it would be to have the housekeeping department of a hospital, hotel or club not only centrally located in the building but also centrally located within its subdepartments. Important, too, is proximity of this department to a service elevator or elevators as conditions demand.

Let us now survey the working conditions of the housekeeping personnel. Have you ever considered the economy and efficiency gained by having satisfactory working conditions?

1. Does the maid or houseman have all equipment necessary to turn out one hundred per cent work?

2. Are floors provided with hopper closets (possibly within an eighteen-room radius) with faucets at a well thought-out height where a pail or mop tank can be easily filled or emptied?

3. Is there a locked cupboard for the vacuum cleaner and other valuable equipment?

4. Is there suitable space for hanging wet mops, brooms, pails and cleaning cloths?

5. Is there adequate locker room space for the personnel?

6. Is the personnel's locker room near the service elevator?

It is not necessary to point out how much valuable time is spent in trying to retrieve equipment which is not safeguarded, to say nothing of the equipment which may not be retrieved. These losses would aggregate in both time and equipment many extra dollars at the end of each year if an inventory could be taken.

The duty rooms or pantries in nearly every hospital as well as hotel kitchen I have visited have been set up with no apparent thought having been given to the height of the sink or the close proximity of working table space, with no provision for garbage disposal and no place to hang unsightly wet towels.

Inadequate storage space is a bugbear to every housekeeper. I have heard more laments on this subject than any other of those that continually harass the housekeeper. Regardless of the capacity of the building, it is not uncommon to find a small storage room in some dark corner of the basement which, in all probability, would not hold more than furniture from a few rooms, with no provision for drainage and ventilation and with poor lighting. Hospital people might well term it a "dark room." It is needless to mention the great furniture turnover in addition to all the extra furniture, mattresses and pillows needed to meet the demands of guests and patients.

From the housekeeper's viewpoint it surely seems that the architect must feel progress stops when his work in construction is completed for seldom is any leeway space provided for future expansion or change of original ideas. The architect may not be psychic or a magician but he could consult the specific department head who could anticipate difficulties and forestall many of the housekeeper's unnecessary worries about needlessly damaged furniture and equipment.

Why Floor Care Is Hard

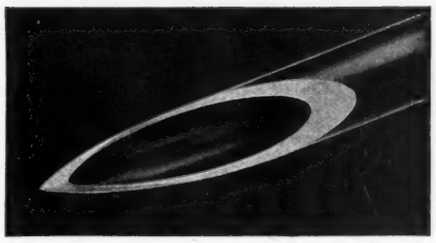
Almost parallel with storage inadequacy complaints, which are universal, comes the question, "What type of floors do you have and how do you service them?" This probably will remain a source of distress to every housekeeper until architectural perfection can be obtained. This holds true principally on poorly installed rubber tile floors. Rubber tile is being used more and more, because of its silencing qualities. No one would question the desirability of silence but can we not be assured that the subfloor is level? Why, after a few weeks, must there be such wide dirt catching cracks between the joinings? Why, after a few weeks, must the tiles at the joints seem different depths?

Anyone who is responsible for servicing this type of floor can understand how much more labor is involved in

Another advance

More than two years ago we started a revolution in the stainless steel hypodermic needle industry by introducing a newly designed point, a radical improvement over any of the then existing ones.

Now we are providing certain refinements to an already-approved product. These changes, while comparatively slight, make the Bishop needle somewhat stiffer and furnish a point with cutting properties which have been carried to the absolute limit compatible with safety.



We say "compatible with safety" advisedly. We believe, above every other quality truly fine needles should possess, Bishop's must *always* be *safe* needles. That is why we have required from the beginning that our points should always partly *spread* tissue (thereby reducing seepage and trauma to a minimum) and not "merely cut."

The seamless tubing from which Bishop needles are made is cold drawn *in our own plant* from "18-8" (18% chromium, 8% nickel) stainless steel. Such steel combines strength with toughness, is not brittle, possesses unusual resistance to heat and the commonest corrosive agents.

Bishop needles are free from oxide and loose scale on the inside and are just as chemically clean there as on the outside. There is freedom from chips, abrasives and burrs.

Bishop needles are not brittle, so often the complaint against carbon steel needles and those made from chrome iron alloys. The flexibility of Bishop needles is an inherent metallurgical characteristic. When this is provided for in technique, it affords a decided advantage, since actual breakage very rarely occurs. Users feel *safe*.

Bishop needles are daily accumulating savings for their users. Prices begin at $9.00 per gross of a single stock size. Ask for details. Your inquiries and orders will receive prompt and careful attention.

STANDARD LUER TAPER

Sold with a money-back guarantee.

"FIRST PLATINUM WORKS JB 1842 IN THE UNITED STATES"

J. Bishop & Co. Platinum Works

MALVERN, PA.

servicing this floor when it is poorly installed. It goes without explanation that this type of floor maintenance would, of necessity, have to be done always by hand scrubbing and hand waxing methods and not by machine scrubbing and waxing methods as it was originally intended to be. Think just how much additional labor is involved in the difference between the old-fashioned hand cleaning and modern machine cleaning during the life of this floor.

We should also like to ask the architect why standardized lighting fixtures and plumbing equipment are not installed in a new building. Just recently one of our hospital women called me and asked if I could tell her where she might purchase a certain type of fixture as she had been informed by several companies that this particular type of fixture was obsolete and it was not possible to obtain parts. This in a building only a few years old! Stop for a moment and think what it means not only to replace these obsolete fixtures but probably to have to redecorate because of this. I have often been told when trying to purchase glass shades for light fixtures, "Sorry, I cannot furnish you with this in a 4-inch fitting—the size is obsolete, we are only making these in 4½-inch sizes now—you will have to buy a whole new fixture."

We face another problem in the transporting of patients and equipment from one unit to another, because the door space is often insufficient to allow beds to be wheeled through and they must therefore be disassembled. This of course increases the need of man power and causes discomfort to the patient. Would it not be wise for the architects and the furnishing manufacturer to get together or for the architect to consult the housekeeper and avoid this difficulty which in this way might easily be overcome?

It is difficult for anyone not actually working within the minutiæ of the housekeeping department to understand how much misplaced energy can be expended and how very costly it can be. The housekeeping department's function is an important one yet it is given least consideration when a construction job is under way. You probably will think I am exaggerating when I tell you that I know of a recently constructed building in which there was not a supply closet, service locker or hopper in the entire building. The housekeeping department's function was just completely forgotten. The housekeeper here probably will be criticized always for being unable to service this building with what would normally be the right amount of personnel. During the life of this building many thousands of unnecessary dollars will be spent for extra labor.

Convenience in the service department's set-up in a hotel or a hospital should be one of the architect's prime considerations. The spending end of any business is of almost equal importance to the revenue end. We who are always on the spending end and who are continuously being cautioned to curtail expenses feel that if more thought were given to the functioning of our department in the architectural beginning, this word "curtail" would be heard less often.[1]

[1]Read at the meeeting of the Tri-State Assembly, Chicago, May, 1937.

THE HOUSEKEEPER'S CORNER

• Objection to the use of rugs in patients' rooms is the result of overemphasis upon germs in national advertising campaigns. This is the opinion that Dr. E. T. Thompson, superintendent, Mount Sinai Hospital, Milwaukee, expressed at the Tri-State round table session in Chicago.

Another participant in the discussion described a test made on hospital rugs. Dirt from two vacuum cleaners was examined and not enough bacteria were found to kill a guinea pig, he said.

With the exception of tuberculosis sanatoriums, it was generally agreed that the use of rugs in private rooms was a good practice for the esthetic value alone.

Some housekeeping directors reported that rugs are taken to the basement for cleaning, while others have them vacuumed in the rooms.

• At the Grant Hospital of Chicago, Mrs. Bessie B. Wright, the new housekeeping director, is reorganizing the department. Mrs. Wright has been in hospital work for a number of years in the capacity of housekeeper, including the St. Luke's Hospital, Cedar Rapids, Iowa; Rochester General Hospital, Rochester, N. Y., and as matron of the house department of the University of Chicago clinics.

• Curtains to brighten up the hallway or lounge — why not? The expense need not frighten you, says Mrs. Mary Schaeffer, housekeeper at the Tompkins County Memorial Hospital, Ithaca, N. Y. For about 25 cents a yard, Mrs. Schaeffer buys crepey unbleached muslin. In this material, which should be shrunk before using, she takes up a two-inch hem, mitres the corners, then stitches bias folding in colors on the edge of the hem. The bias folding may be had in two or three colors overlapping. Particularly effective is a combination of rust, peach and pale green. The cost of this binding is 10 cents a yard. If a more elaborate effect is desired, the material may be cut in large scallops and the bias foldings stitched around them.

• Katheryn Kugler of Jeannes Hospital, Fox Chase, Pa., was elected president of the Philadelphia chapter of the National Executive Housekeepers Association at a recent meeting. At the same time Kathryn Peileke of Eaglesville Sanatorium was made vice president, Beatrice Wool of the Home for Consumptives, recording secretary, and Elizabeth Hazelgrove of Germantown Hospital was elected to the board of directors.

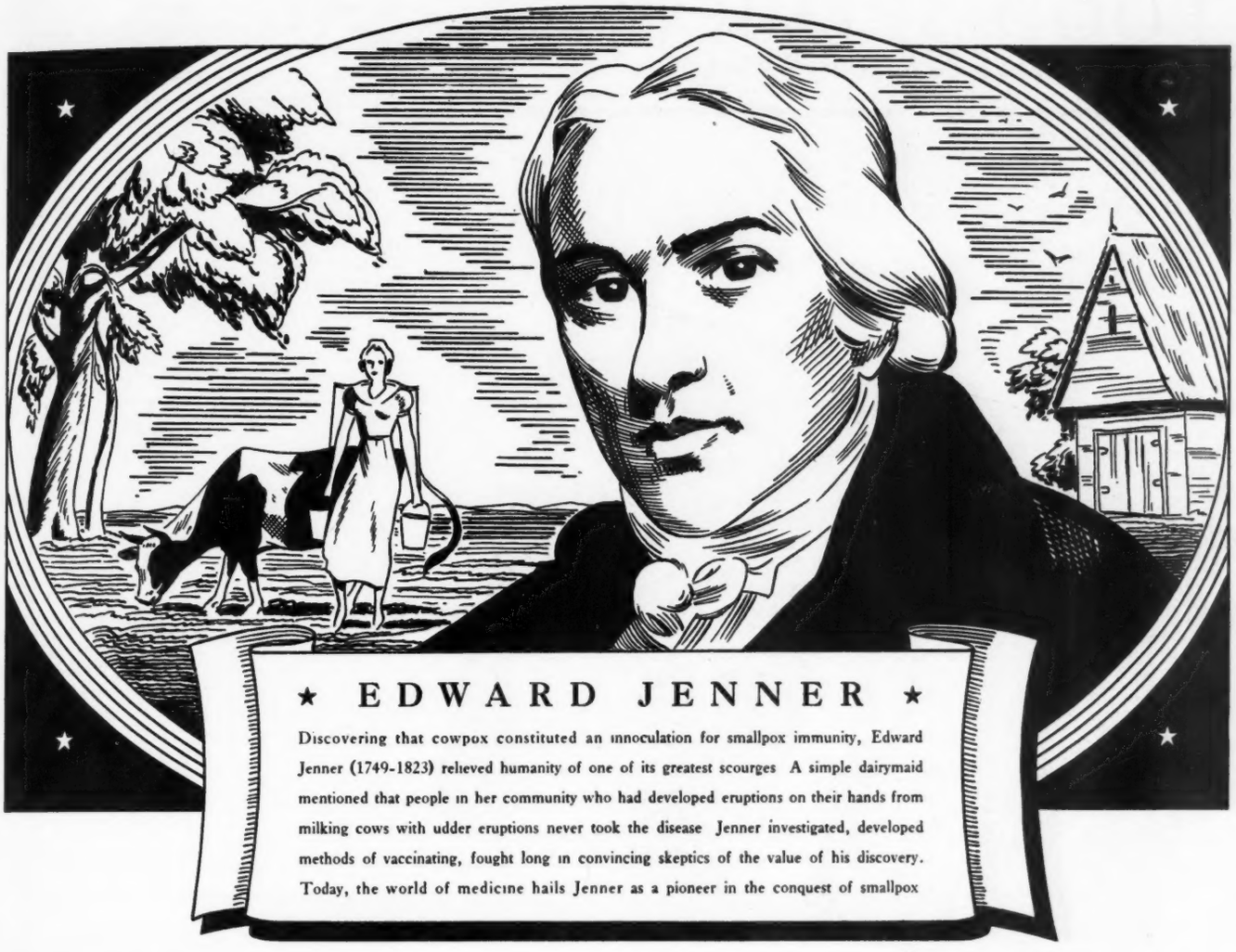
• How do you know who is on the job and who is missing? In lieu of the time clock try a small bulletin board affixed to the wall in your office. One may easily be made by taking a wooden frame and inserting in it a piece of composition board. Nail neatly on its surface metal card holders procurable at any hardware store for a few cents, and insert in each the name of the individual. Now under each name screw a small hook on which a cardboard tag marked "In" and "Out" may be hung. On reporting for work the employee merely removes the "Out" tag hung under his name and replaces it with one marked "In." A glance at the board each morning indicates those present and missing. Again we are indebted to Mrs. Dungan of West Jersey Homeopathic Hospital, Camden, N. J.

• Larger hospitals are employing hotel trained housekeepers, according to Mrs. LaBelle, because of the esthetic value in having a housekeeper with some knowledge of interior decoration. Professional interior decorators, who may be obtained to donate their expert knowledge and advice to hospitals, are not practical, Mrs. LaBelle believes, because they are inexperienced in hospital problems.

• Caroline Meyer of the Stevens Hotel was elected president of the Chicago chapter of the National Executive Housekeepers Association at the June meeting. Miss Meyer served as vice president last year.

In the entire Stevens Hotel—3,000 rooms and 3,000 baths—there is only one rocking chair, we are informed. Only one person ever asks for it, a Mr. White from New York. When Miss Meyer sees that he has made a reservation she makes it a point to have the rocking chair in his room when he arrives. Hospital housekeepers often get a chance to satisfy some similar whim or preference of staff or patient.

PIONEERS IN MEDICINE AND SURGERY • NO. 18



★ EDWARD JENNER ★

Discovering that cowpox constituted an inoculation for smallpox immunity, Edward Jenner (1749-1823) relieved humanity of one of its greatest scourges. A simple dairymaid mentioned that people in her community who had developed eruptions on their hands from milking cows with udder eruptions never took the disease. Jenner investigated, developed methods of vaccinating, fought long in convincing skeptics of the value of his discovery. Today, the world of medicine hails Jenner as a pioneer in the conquest of smallpox.

FOOD SERVICE • • • • •

Conducted by Anna E. Boller, Rush Medical College

A New Science—Kitchen Therapy

By Mary Willsie

Anna drying pans

Billy making cake

THE aim of the House of St. Giles, a convalescent home for crippled children in Brooklyn, N. Y., is to prepare the child for the life he will have to meet socially, physically, mentally and economically. Naturally, we cannot thoroughly prepare the child to earn his own living, but we can give him the idea of a well kept, clean home. And this is one of the things many of our children have not known before coming to us.

As modern educational trends suggest training the child very early in life, even in home economics, we can come in on the ground floor, for the majority of our children are young. I will deal first with the general set-up of our meal preparation. Each child has a specific job, before and after each meal.

A girl of twelve, assisted by a little girl of six, sets the tables. When they come in to begin work I go over the menu and tell them what dishes and silver are needed. Quickly they pile necessary dishes on a small rubber-tired cart, and fifteen to twenty minutes later the tables are neat and ready for the family to sit down. Just before the last bell I walk through the dining room to see that everything is done properly. It usually is, for the girls are conscientious and proud of the short time it takes them to set six large tables.

When the meal is ready the food is rolled in to the serving room on a large cart, and quickly carried around by a group of small boys.

Two boys and two girls are my kitchen assistants after every meal. The girls, who have difficulty in getting around rapidly, wash and dry the pans. The boys put away the food, wash the tables and stoves, sweep the floor and mop when necessary. I help when needed and do general supervising. Our work is accomplished easily and quickly, and the children are far better off learning such things than running wild.

The general work with the children also includes preparation of fruits and vegetables for the day. This is done directly after breakfast by any group I can get together. With so many to help, this really is a short, easy job.

In my work with the children I have tried to incorporate therapeutic treatment. Having little knowledge of therapeutic correction for the physically handicapped, I believe my results are not very astonishing and do not show up what I have tried to do, as greatest progress in the case of infantile paralysis is made during the first year of convalescence, then slowing up for the next two to three years. The majority of our cases are at the five-year stage, so any therapeutic treatment they might receive by helping in the kitchen for a period of four months will not show definite results. Muscle strength also is difficult to determine.

Must Be Immaculate

For my project I have chosen all children who were physically able to do anything, however small the job. When each child comes into the kitchen he knows he must be clean, have his hair neatly combed and have on a clean apron, ready for work. All understand that they must be immaculate when working with food.

1. Anna is a little girl of seven who has been with us for six months. Her stay here is in preparation for an operation. A slight case of infantile has affected the left ankle and foot. Exercises to strengthen the ankle and straighten the foot have proved ineffective. A reenforced shoe has given no satisfactory results.

Regardless of age or size Anna has adapted herself most beautifully to the study of home economics. With very little help she can make a cake to serve our whole family. More than other children she is interested in knowing why the butter and sugar should be thoroughly creamed, and what the soda does; but the "try" cake is always a sample! To finish off her cake Anna makes an icing of confectioner's sugar. The finished product would be a source of pride to anyone, to say nothing of a seven-year-old. Among her other accomplishments are cocoa, sandwiches, coffee and mixed fruit dessert.

Knowledge of home economics seems to be more than a passing fancy with Anna. I think she is really interested in learning, and with only a slight handicap she should be able to do quite well as she gets older.

With the exception of a stabilized ankle, her foot in time will be in perfect condition. Since she has been helping in the kitchen she has shown no improvement, except in general health, but on the other hand she has not lost strength in her one bad foot.

2. June is one of our worst polio cases. Besides a spinal curvature, she

SAFE WEANING—

The Baby Regulates Breast Feeding

An Obligation to Infants

The Doctor Regulates Bottle Feeding

INFANTS should be weaned from the breast at eight months. The season of the year is immaterial with modern knowledge of nutrition and hygiene. Gradual weaning is desirable. It is accomplished by progressively increasing the number of bottle feedings in substitution for the breast feedings.

The formula consists of 6 ounces milk, 2 ounces water, 2 teaspoons Karo for each bottle—one the first week; two the second, etc. The schedule for additional foods remains the same as during nursing. But babies unaccustomed to the bottle often refuse it as long as the breast is available. Then abrupt weaning becomes necessary, some person other than the mother giving the feedings.

The formula in abrupt weaning prepared for the entire day consists of 24 ounces milk, 8 ounces water, 3 tablespoons Karo, divided into 4 feedings, 8 ounces each, at 4 hour intervals. The formula can be concentrated once the baby is adjusted to the bottle feeding.

Karo is a mixture of dextrins, maltose and dextrose (with a small percentage of sucrose added for flavor) practically free from protein, starch and minerals. Karo is a non-allergic carbohydrate, not readily fermentable, well tolerated, readily digested, effectively utilized and economical for both the baby and the budget.

Feeding	*1st Week*	*2nd Week*	*3rd Week*	*4th Week*
6:00 A.M.	Breast	Breast	Breast	Bottle
10:00 A.M.	Breast	Breast	Bottle	Bottle
2:00 P.M.	Breast	Bottle	Bottle	Bottle
6:00 P.M.	Bottle	Bottle	Bottle	Bottle

For further information, write

CORN PRODUCTS SALES COMPANY
Dept. H-7 , 17 Battery Place, New York, N. Y.

★ Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.

has weak abdominal muscles, arms and legs. She wears a back brace, extending into a leg brace on the left leg.

It has been difficult to plan things that June is able to make. Her work is limited to that which can be done only at elbow height, for she cannot lift her arms. With difficulty she has helped prepare materials for a cake. Stirring is rather impossible, so she cannot make a finished product, but she is interested in what she can do. June butters toast nicely and fixes the butter and jelly dishes for lunch.

No physical exercise will ever help June. She gradually will get worse, for no medical aid can cure or do much to arrest her condition.

Exercise Helps Milly

3. Mildred's afflictions are similar to June's. Her arms, back, abdominal muscles and lower extremities are badly crippled. Her legs are huge, and on one she wears a brace. She also uses crutches. Some doctors believe she is also afflicted with glandular trouble, causing her legs to be oversized.

By having help with the large bowls, Milly is able to use the mixer. Her arms seem to have benefited somewhat from this exercise. A similar movement is chopping, and she has prepared vegetables for soup and made delightful slaw from new cabbages. She is also adept in making cocoa, but oftentimes loses control of the spoon, and the spilled sugar is more trouble to clean up than actually doing the work. Milly will never be any better than she is now.

4. Charles is handicapped in both the arms and legs, and the back. He wears a back brace and one leg brace. Exercises to develop these muscles are desirable, but Charlie is rather lazy, and it is a job to get anything out of him. He does seem much interested in his kitchen duties, and invariably comes in with his black shiny face in smiles.

His work has been confined to easy jobs, such as buttering pans, holding the electric egg beater and sifting flour. The last has been good for him, for both hands are required to perform the task, and then it takes him a long time. Charlie even made spaghetti, which consisted of opening two large cans and putting the spaghetti in shallow baking pans, and covering it thinly with chili sauce.

As Charlie grows older, and if he continues to get nutritious body-building food, his muscles may develop slightly, but never enough to discard braces.

5. Seena had a slight touch of polio which affected only the lower legs. Any exercises for the feet and ankles are desirable. With another operation her feet will be in fairly good shape, and she will be able to walk normally. Her posture also should be corrected.

Seena is a bright little girl of ten, who has learned to do many things well. Her favorite work is preparing salads, either cutting vegetables into dainty bits or placing a fruit salad in an attractive cup of lettuce. Along with salads she makes a dressing, appropriate in each case. This brings in the use of the electric beater, which is the ultimate goal of all my assistants. As have most of my helpers, Seena has learned to make cakes. She likes a spice cake the best of all, baked in individual tins.

After some special training in walking without a limp, Seena will be practically cured. She has improved considerably of late.

6. Robert has a fairly bad case of polio, one leg being entirely useless. He wears a brace at all times. He has individually prescribed exercises for the various muscles of the leg. He is a rather nervous child and tires of one thing quickly. To keep him interested I have given him jobs that are quickly done; consequently he has not learned to cook or bake. He has learned to mix the cocoa, and knowing measurements has been some accomplishment. There are many little things to get ready before each meal, and he likes to fix the butter, jelly and cheese, and dish the fruit.

Robert's bad leg is growing weaker all the time, owing to lack of exercise. Because of overexercise, the other leg is too far developed and has become longer than the other. If he were taught to walk rhythmically instead of hopping, his bad leg would develop. In getting around for dishes, I encourage him to take time and to think of how he walks. However, his leg will never be of much use, and he will always have to wear a brace.

7. Elaine has much the same handicap as Seena, that of the ankle and foot. She will soon discard one brace and after another operation she can get along nicely without the other.

It has not been easy to work with Elaine. She is slow and inclined to be messy. As neatness and cleanliness are first requirements of home economics, it has taken most of my time to teach her a few simple rules regarding them. We had a rage on candy making and it took weeks for Elaine to learn how to measure, so nothing was really accomplished. She has made several sandwich fillings, and likes to grind onions and pickles.

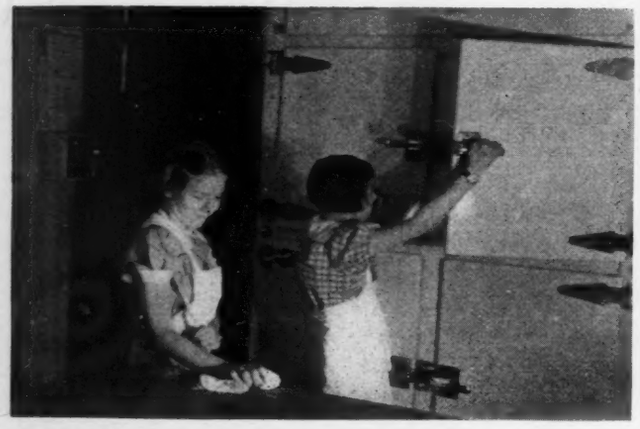
In time, and with the proper instruction in posture and correct walking, Elaine's feet will be nearly normal.

He's an Enthusiastic Helper

8. Polio has greatly handicapped both of Ronald's legs, but a brace on one of them is all that is necessary at present. Any type of exercise for the lower extremities is beneficial.

Ronald is one of my most enthusiastic assistants. All he wants to do is make cup cakes, so we kept at that until he became efficient. He sifts and measures flour, beats eggs and fills the pans like a veteran. He has helped in making seven-minute icing, and when his cakes are ready for the table each has a little peak on top.

Ronald may improve a little as he



Willing Workers

Etta and Mildred

grows older, but always will be greatly handicapped.

9. Norma is afflicted with a disease known as idiopathic scoliosis. At present she wears a plaster jacket to correct the spinal curvature. Anything for activity is very much to Norma's advantage. Since her operation she has been afraid to walk and seemed stiff. We think this may have been caused partly by self-consciousness.

Norma is fourteen, and should take

Norma setting the table

an active part in our meal preparation. She is a difficult person with whom to work, having the idea she already knows what is being taught her, consequently she does not follow directions at all well. She has learned how to make cookies, prepare mixed fruit and make cocoa. Norma can make a cake, but is very slow, and I can't get her to be accurate in her measurements. She isn't particular in the way she carries on her work, and invariably finishes with a messy kitchen, although I have tried to teach her that pans should be washed and the kitchen kept tidy while she is working.

It is indefinite how long Norma will have to wear a cast, but she has shown remarkable improvement since being with us, and all indications show that she will continue to do so.

10. Jean is handicapped by congenital contractions and a dislocation of the hip. There is no motion in the knees or ankles. She has prescribed exercises for the hips and lower extremities.

Jean's mental capacity will never carry her very far, therefore her work has been very simple and requires careful supervision. She tires quickly from being on her feet, and her work has been confined to things which can be done sitting down. These duties have included chopping nuts and flouring raisins for muffins, buttering pans, measuring and sifting flour. She also has helped in the preparation of vegetables for soup and has cut fruit for salad. That is about all she will ever be able to do.

Medical science can do no more for Jean, but it is thought that good food, plenty of rest, and the correct exercises will maintain her condition.

11. Billy has a condition known as Erb's palsy, affecting the left arm. All exercises for the shoulder, wrist and hand are definitely to his advantage. A forcible stretching of the arm will develop the muscles.

Bill can perform nearly all activities with one arm that many children can perform with two good arms. When scraping potatoes or carrots he holds the vegetable against his body with the deformed arm and scrapes with the other. As much as possible I have him use the food grinder, can opener, and the lever on the large electric mixer. Anything to make him use his weak arm is beneficial.

Billy's arm never will be normal, nor will he have much use from it, but with the proper exercise, it should continue to be as much use as it is at the present time.

12. The next two children are sisters who have been afflicted with rachitis, which is an inadequate laying down of calcium and phosphorus in the bone. Both are very short for their ages and the doctors believe they have some type of dwarfness, but the cause cannot be determined. For some time they have been given calcium gluconate and five grains per day of whole pituitary gland extract. As yet no satisfactory results to produce growth have been obtained.

Claire and Jean must pull a high stool around to every place they work, and as a result they do not accomplish much. Nevertheless, they are earnest little girls and have learned to make drop cookies, cocoa and cup custard.

Good food to aid their legs in growing straighter is all that can be done for Claire and Jean. They always will be dwarfed.

Johnny Makes Progress

13. Johnny is a little colored boy who came to us with a bad case of rachitis. He had been found in a dark, damp, filthy cellar with one old man. The poor boy had scarcely enough to eat. At the age of seven, when he was brought to St. Giles, he had no teeth whatever and he hardly could chew food. At the present time his legs are fairly straight and his teeth are in good condition.

Johnny is one of my most ardent and enthusiastic workers. He even peels potatoes with gusto. Anything to be in the kitchen. He delights in using the food grinder, opening cans and chopping cabbage. At one time he was creaming butter to put in sandwich filling and in his anxiety to get it done and do a good job he bent the spoon completely double.

Johnny is physically able to do practically any type of exercise and work, but he will always be a little chicken breasted and flat-footed.

14. The next four children I shall discuss as a group. All have been on a Bradford frame from one to four years. They represent every stage of Pott's disease, which is tuberculosis of the spine, from the beginning to what the doctors believe is a perfect cure. A person with this type of disease always is overactive and any work given them should be mild.

At present Nan wears a plaster jacket. She should have as little activity as possible and do no heavy lifting. Nan is out of bed only six hours a day.

Rose also wears a plaster jacket and it is indefinite how long she will have to continue to do so. She underwent a spinal fusion, but the operation was not completely successful. She is allowed slightly more activity than Nan.

Tom is at a more advanced stage than either of the girls. He wears a corrective back brace day and night and can do any type of exercise, with the exception of heavy lifting.

Eugene, the oldest of this group of children, is thought to be perfectly cured. However, he wears a back brace half of each day to make sure there will be no recurrence of the disease.

Nan and Rose love to make cottage pudding with lemon sauce. They have also fixed baked apples, filled with nuts and raisins.

A Cafeteria Project

Tom and Eugene have been working on a cafeteria project, which we carry out every Friday. They have made cost cards and counter signs. The prices of our food correspond with those found in a real cafeteria. From this they have derived a fair knowledge of food costs, and how food can be made sufficiently attractive to sell.

Doctor Napier, who is chief of medical staff of the House of St. Giles the Cripple, says there is no doubt but that the work I have given the children has improved them to some degree, but to what extent it is hard to determine. What with their other activity and prescribed exercises there is no positive check on my work. There is, however, a definite positive result in the social side. Each child is made to feel that St. Giles cannot properly exist without him. Outwardly, his handicap is nothing and he is made to feel that he is no different from the normal child, and that there is a definite place for him in our scheme of living.

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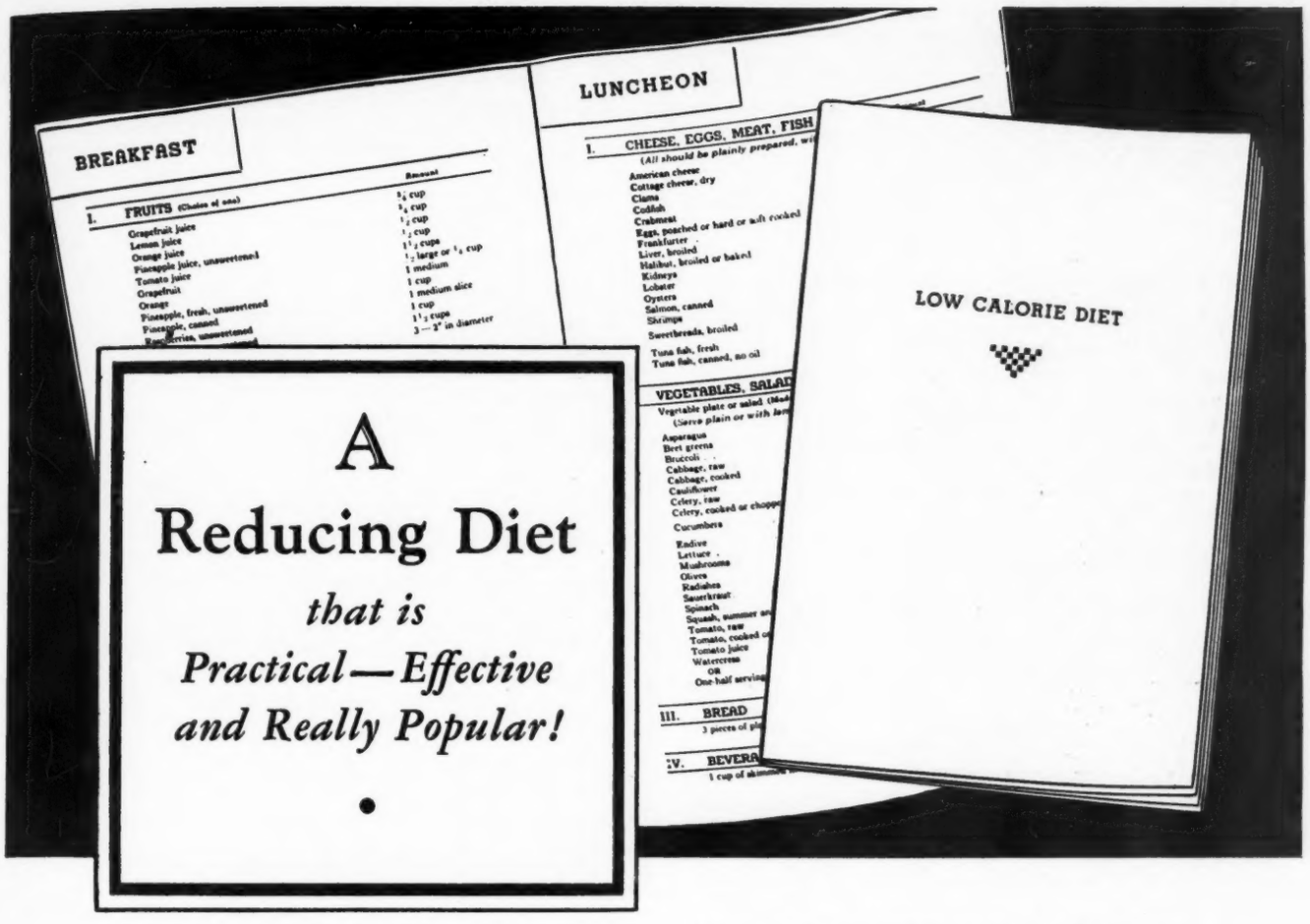

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The Cream of Economy

By Mary Edna Golder

IN THESE days when budget expenditures mean so much to hospital dietary directors the counter freezer salesman is about the most welcome person to enter the dietitian's office. He has a machine which can save money and at the same time provide a fresh product.

During the last fifteen years consumption of ice cream has increased so much that its manufacture has become one of the leading industries in the country. Dietitians who have purchased counter freezers have miniature ice cream factories, and no longer need worry about the cleanliness of the commercial product. The preparation of this popular dessert may be supervised in the kitchen with little additional effort. In most cases commercial ice cream is made in large buildings located in congested districts. Machinery is heavy, the help poorly paid, and from all appearances cleanliness is not a source of pride.

What Type Shall We Buy?

At St. Anne's Hospital, Chicago, food is simple, wholesome, attractive and possesses a home-cooked flavor. There are no French chefs but we do strive to please the patients. When the "hurdy-gurdy" type of ice cream freezer at St. Anne's began to show signs of old age and the engineer rendered a not-repairable verdict I did not know what type of machine should replace our old one.

Being a subscriber to a trade publication advertising this type equipment, I informed them we were in the market for a counter freezer ice cream machine and asked that they inform companies manufacturing this piece of equipment. Six or seven leading manufacturers sent representatives. A tribunal consisting of the Mother Superior, the engineer, and the dietitian, selected the machine.

Counter ice cream freezers are built in 2½ and 5-gallon sizes. One and one-quarter gallons of fresh ice cream mix (which can be delivered every day from the creamery) will produce 2½ gallons of fine quality ice cream of any desired flavor—a smoother, fresher, more palatable product than may be purchased from commercial manufacturers. Since commercial ice cream is made in large quantities and stored until time for delivery, the original flavor of the product is killed and the texture changed. Counter freezers can produce four batches within an hour and patients are served a product made under strict sanitary conditions.

The vertical type freezer is as easily cleaned as the orange juice extractor and will not break. Mixes vary in butter fat, some having a 12 per cent butter fat and others 14 per cent and 16 per cent. We use the 14 per cent content although the state requirement is only 12 per cent. The 14 per cent content is homogenized, and contains a vegetable stabilizer, sugar, milk and cream solids.

The machine paid for itself with savings on a thirty-six weeks' commercial ice cream bill. That is, if we had purchased the same amount of ice cream served during a thirty-six weeks' period, the savings between the actual cost of our product and a product delivered was the price paid for the machine. The cost of operation and depreciation is negligible. No other employees were needed to operate the machine because the butcher and meat cook also makes the ice cream. Instruction was given by the freezer manufacturer and monthly ideas were mailed by the freezer association.

Cash was paid for the machine to obtain the 2 per cent discount. Most companies also offer a budget purchase program. Payments in most instances may be carried over a three-year period and in no instance do the monthly payments exceed $33.

No food which can be served on almost any type diet, including the diabetic ice cream and sherbets for the milk-free diets, offers the dietitian more pride and satisfaction than counter freezer ice cream.[1]

[1]Read at the meeting of the Tri-State Assembly, Chicago, May, 1937.

The Dietitian's Rôle in a Small Hospital

By Marian Miles

The Holston Valley Community Hospital, Kingsport, Tenn., is the newest of seven hospitals sponsored by the Commonwealth Fund. We serve from twenty-five to thirty in the staff dining room, from thirty to forty trays and fourteen in the help's dining room. We have four kitchen boys, one cook, one boy who sets up the trays, keeps the refrigerators and storeroom and helps in scraping and washing dishes. Another boy waits on the staff dining room, makes salads and helps with the dishwashing. The fourth boy washes pots, prepares vegetables and does the special cleaning work. Each is trained to work in another's place which we consider important. The cost of food preparation and service per person is about $0.35.

The dining room is open for one hour each meal and all trays are served in approximately thirty minutes. With a few exceptions nurses and patients are served practically the same menu as this is time-saving and labor-saving.

The food is served from a steam table on to plates that have been heated in the table. The dietitian directs the tray service giving special attention to the likes and dislikes and various needs of the patients. The trays are then placed on tray carts and carried directly to the rooms by the floor attendants. Nourishments are prepared and served by the floor attendants at the direction of the dietitian at 10 a.m. and 3 p.m.

Every hospital is interested in its food cost and this we endeavor to control in two ways: by efficient buying and by careful control of waste. Form quotation sheets are given the salesman with needed items checked. These sheets are filed and kept on record. A food cost graph is kept in the dietary office and reasons for the rise or fall of food cost are analyzed.

We make our trays as attractive as possible. The china is a pleasing buff color and attractive linen tray covers are used for private patients. The plates are made more tempting by the use of suitable garnishes and on special occasions favors and mimeographed menu greeting cards are used. On Sunday the churches send flowers for our trays.

The food service is a vital factor in the establishment of public opinion for or against the hospital. Hospital food is often the subject of conversation between patients and visitors and we try to make it a boost for our hospital.

Food service in a small hospital is interesting work, and there is every opportunity for the dietitian to express her ideas.

Controlling Spoilage

The preservation of food has been the subject of much recent study by the Consumers' Counsel of the Agricultural Adjustment Administration. The loss of fat and general deterioration of corn meal in hot weather may be prevented by storing the meal in an icebox. If this is not possible, the meal should be thoroughly dried and kept in closed containers. Cured meats, such as ham and bacon, do not spoil as readily as fresh meats but they do develop mold. This may be held in check by keeping them in the ice box. Shrinkage is lowered if they are kept in a covered container. Paraffin paper is good for storing bulk sausage, parchment paper for sausage in casings. Dried beef will be kept from shrinking by either paraffin paper or a covered container. Ready to serve meats should be kept in the coldest part of the icebox.

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Ward Luncheon Tray

Tomato broth, duchess potatoes, bacon strips, lettuce salad, whole wheat bread, baked apple.—*Nelda Ross, dietitian, Presbyterian Hospital, New York City.*

Lamb Chops

The broiled lamb chops shown are cut from the loin with the ends rolled around and fastened. The oven is preheated and the chops are placed on the rack, far enough from the heating element so that, when they are browned on one side, they will be about half done. If the heat is turned to "high" this distance should be about three inches. The chops are seasoned with salt and pepper, turned and allowed to brown on the second side. The pineapple slices are dredged in seasoned flour and browned in hot dripping. The salad is grapefruit and fresh berries in lettuce cups, with mint leaves.—*Inez Searles Wilson, Chicago.*

FOOD FOR THOUGHT

• A new advantage from adequate vitamin A consumption has been suggested by Dr. Ira A. Manville of the University of Oregon medical school. Experiments reported by him seem to indicate that there is a connection between vitamin A and a mechanism for protecting the body from poisons. Damage to mucous tissues such as line the inside of the eyelids is one of the signs of vitamin A deficiency. This same damage occurs in the mucous lining of the digestive tract when vitamin A is lacking.

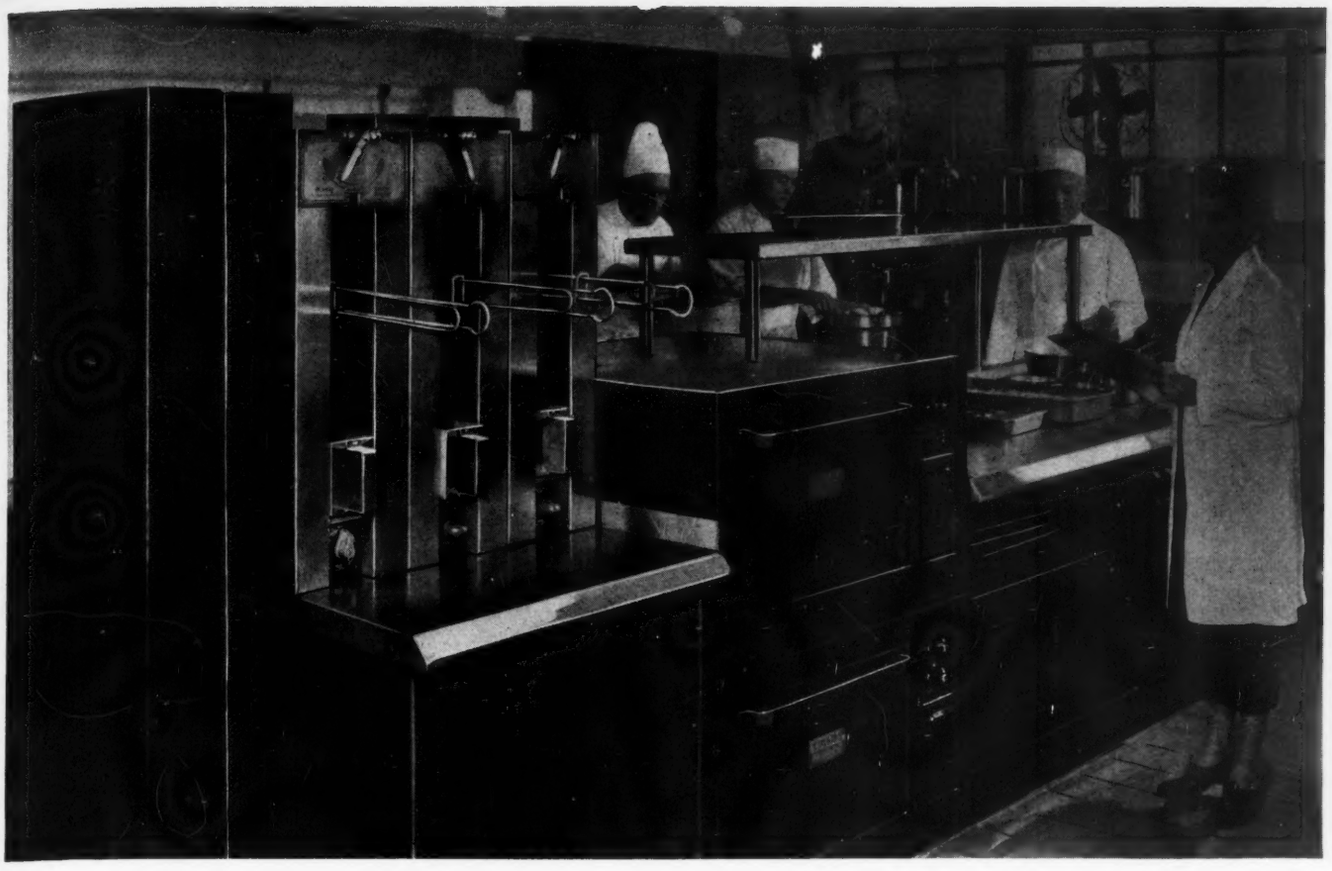
The lining of the stomach is protected by mucin, which has for one portion of its molecule a substance called glycuronic acid. This acid helps the body get rid of certain kinds of poisons by a chemical process of detoxification. It is obtained by the body from food and its own protein building blocks. When poison is present in the body, all available glycuronic acid will be called upon to detoxify the poison, and if the diet is low in foods supplying this acid, none will be left over for mucin production. Doctor Manville was able to produce ulcers in the stomach, gall bladder, pylorus and both large and small intestines, by depriving animals of a food source of glycuronic acid.

Doctor Manville believes that vitamin A is involved in this mechanism, but is not yet able to explain the exact connection between the vitamin and the detoxifying acid and the development of ulcers.

• In a paper presented before the American Dietetic Association, Gordon B. Koch, an industrial engineer from Kansas City, Mo., made the statement that one of the greatest developments of recent years has been the electric fry kettle. He said that in the past it has been considered practically impossible to serve a digestible fried product, but with the new electric fry kettle foods can be fried which are not grease-soaked and indigestible but grease-cooked and digestible.

This is accomplished by the application of electric units into the frying compound at a point which allows part of the compound to be thermostatically controlled at a given temperature, and the lower portion of the compound maintained at a considerably cooler temperature. This allows the particles falling from the food to drop into the cooler grease and remain there without burning and affecting the grease.

By regulating the temperature of the heating element, the compound is never allowed to reach a point at which the component parts are separated. Thus it is possible to predetermine the proper temperature at which foods should be fried and to protect the frying compound against harmful deterioration.



With this new Edison all-electric equipment 1500 meals a day are prepared under the direction of Miss Reeva Hinyan, Dietitian, for patients of both the California Hospital and the children's department conducted as the California Babies Hospital. Electric broilers and ovens, electric griddle and cooking surface, an electric deep fat fryer, all help to improve cooking and make foods more appetizing.

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August Breakfast and Supper Menus

By Louise Wilkonson

Chief Dietitian, Barnes Hospital, St. Louis

	BREAKFAST		SUPPER			
Day	Fruit	Main Dish	Main Dish	Potatoes or Substitute	Salad	Dessert
1.	Honey Ball Melon	Bacon	Baked Stuffed Peppers	Lima Beans	Vegetable Combination Salad	Caramel Blancmange With Whipped Cream
2.	Bananas	Cinnamon Rolls	Luncheon Meat Sandwich, Pimiento Cheese Sandwich		Molded Fruit Salad	Cookies
3.	Fresh Plums	Scrambled Eggs	Cold Sliced Meat		Potato Salad	Applesauce
4.	Grapes	French Toast With Syrup	Baked Beans		Head Lettuce, French Dressing	Fruit Cup
5.	Grapefruit	Cornmeal Mush	Luncheon Tongue Sandwich		Sliced Tomatoes	Red Cherry Sauce, Caramel Squares
6.	Stewed Apricots	Sausage Links	Pineapple and Cottage Cheese Salad	Baked Stuffed Potatoes		Gingerbread, Foamy Sauce
7.	Cantaloupe	Fried Eggs	Baked Tomatoes Stuffed With Macaroni and Cheese	French Fried Egg Plant		Stewed Fresh Plums
8.	Pineapple Juice	Broiled Ham	Hamburgers on Buns		Kidney Bean Salad	Watermelon
9.	Fresh Sliced Peaches	Black Walnut Coffee Cake	Deviled Eggs	Potato Chips	Pear and Cream Cheese Salad	
10.	Grapes	Hot Cakes With Syrup	Fricassée of Veal	French Fried Sweet Potatoes		Apple Delight With Whipped Cream
11.	Tomato Juice	Soft Cooked Eggs	Ground Meat Sandwich, Peanut Butter Sandwich		Cabbage and Green Pepper Salad	Maple Mold, Custard Sauce
12.	Honey Ball Melon	Bacon	Italian Spaghetti	Mustard Greens		Fresh Fruit Cup
13.	Fresh Plums	Muffins and Jelly	Cold Sliced Meat	Rice Croquettes With Jelly		Fresh Peaches With Cream
14.	Bananas	Scrambled Eggs	Toasted Cheese Sandwich	Creamed Asparagus	Head Lettuce, Thousand Island Dressing	Cantaloupe
5.	Stewed Prunes	Raisin Bread Toast	Creamed Dried Beef on Toast	Green Beans		Fruit Gelatin, Custard Sauce
16.	Cantaloupe	Bacon	Assorted Cold Meats	Sliced Cucumbers	Potato Salad	Cup Cake, Chocolate Sauce
17.	Grapefruit	Fried Eggs	Russian Meat Balls	Escalloped Corn	Cabbage Slaw	Watermelon
18.	Bananas	Sausage Cakes	Grilled Tomato and Cheese Sandwich With Bacon			Applesauce and Gingersnaps
19.	Stewed Apricots	Cornmeal Mush	Hot Roast Beef Sandwich		Head Lettuce, Chili Mayonnaise	Chocolate Pudding
20.	Cantaloupe	Soft Cooked Eggs	Baked Stuffed Tomato		Pea, Pickle and Celery Salad	Watermelon
21.	Oranges	French Toast With Syrup	Vegetable Plate		Cottage Cheese Salad	Peaches With Cream
22.	Pineapple Juice	Sausage Links	Deviled Eggs	French Fried Potatoes	Pineapple and Coconut Salad	
23.	Grapes	Coffee Cake	Broiled Bacon		Sliced Tomato Salad	Spice Cake
24.	Honey Ball Melon	Sausage Links	Hamburgers on Buns	Dill Pickles	Carrot and Raisin Salad	Apple Delight With Whipped Cream
25.	Fresh Plums	Hot Cakes With Syrup	Minced Ham Sandwich, Date and Nut Sandwich		Tomato Salad, French Dressing	Cantaloupe
26.	Bananas	Scrambled Eggs	Meat Pie With Biscuits		Cucumber Salad	Applesauce and Cookies
27.	Stewed Peaches	Bacon	Sandwich Plate			Fresh Peaches With Cream
28.	Cantaloupe	Fried Eggs	Baked Stuffed Peppers		Head Lettuce, Fancy Dressing	Fruit Gelatin, Marshmallow Sauce
29.	Grapes	Raisin Bread Toast	Creamed Dried Beef on Toast	Buttered Asparagus	Banana Nut Salad	
30.	Fresh Sliced Peaches	Black Walnut Coffee Cake	Molded Sweetbread Salad	Sliced Tomatoes	Potato Salad	Cookies
31.	Oranges	Soft Cooked Eggs	Ground Meat Sandwich, Peanut Butter Sandwich		Vegetable Combination Salad	Watermelon

Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago. Space precludes listing of cereals, breads and beverages. Several varieties of well known cereals are always offered for breakfast.

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AIR CONDITIONING
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NEWS IN REVIEW • • • •

British Columbians Vote for Health Insurance; Physicians Dissatisfied With Present Bill

The future course of health insurance in Canada, and perhaps in the United States also, was at stake recently in Canada's most western province. On June 1 the voters of British Columbia were called upon to vote on the following question: "Are you in favor of a comprehensive plan of health insurance progressively applied?"

The movement for health insurance in British Columbia first took concrete form when a Royal Commission on State Health Insurance and Maternity Benefits was appointed by the government in 1929. This committee, reporting in 1932, strongly urged a system of compulsory health insurance for the employed population of the province earning less than $2,400 per year.

Hon. G. M. Weir, provincial secretary, shortly thereafter appointed a committee to formulate a program. This was prepared, together with a draft bill, and presented in 1935. Criticisms of the proposed bill stimulated the secretary to appoint a hearings committee to take public testimony and suggest amendments. This hearings committee was headed by Dr. Allon Peebles, former teacher at Columbia University, research worker for the Committee on the Costs of Medical Care and insurance executive for Northern States Life of Canada. He was appointed as adviser on health insurance to the provincial secretary.

Other committee members included Dr. A. Grant Fleming, secretary of the committee on economics of the Canadian Medical Association; Grace Fairley, superintendent of nurses, Vancouver General Hospital; E. W. Neel, president, British Columbia Hospitals' Association, and representatives of labor and manufacturers.

What Committee Recommended

After extensive hearings in eighteen British Columbia cities, the committee recommended (a) excluding cash benefits; (b) limiting benefits in the beginning to essential medical service, namely, physicians' services, hospital ward care, diagnostic x-ray and laboratory service, part payment for essential drugs, and such preventive health services as may be financially feasible; (c) omitting services of osteopaths and chiropractors; (d) commencing benefits one month after contributions; (e) continuing existing government health services.

At the insistence of the medical profession the limit of eligibility was dropped from $2,400 to $1,800, both for compulsory and voluntarily insured persons. The original provision for accepting indigents at one-half pay was deleted and the committee recommended that responsibility for their care at full pay be entirely assumed by the provincial government, but that "indigents" be defined as persons "actually dependent for their support on public funds."

The hearings committee also recommended that the contributions be 2 per cent of salary for employees and 1 per cent of pay roll for employers with minimums of $16 and $8 a year, respectively. A simplification of administrative machinery was also recommended.

What Assembly Passed

When the bill was actually passed, some of the recommendations of the hearings committee were disregarded. The most important was omission of any provision for care of indigents and of any contribution by the provincial government.

As a result of the reduction of the income limit at the insistence of the doctors as well as the omission of government contributions, the funds expected to be available were smaller than had been previously anticipated. The Health Insurance Commission, after extensive study, determined to pay the doctors $5.50 per insured person per year instead of paying on a fee for service basis. (The minimum specified in the act was $4.50 per person).

While the act permitted payment of physicians on a salary, fee or per capita basis, the commission in deciding on the per capita basis declared that the fee system was unsound and pointed to the universal use of the per capita system in England. It also called attention to the additional amounts that physicians will receive from insured patients for workmen's compensation, x-ray and other services, which, it estimated, would bring the total compensation to about $7.30 to $7.50 per insured person.

The doctors, nevertheless, were dissatisfied and in a poll of members in March voted 619 to 13 against the health insurance plan. The government immediately stopped collection of funds and submitted the question to the voters.

In an election on June 1 the British Columbia voters disagreed with the doctors by a vote of approximately 75,000 to 55,000. As a result, without doubt health insurance will be established in British Columbia.

Two Headliners at A. H. A. Convention Are Announced

A message of hospital administration from the British Isles will be brought to the thirty-ninth convention of the American Hospital Association convening in Atlantic City, Sept. 13 to 17, by Capt. J. E. Stone, secretary of the Hospitals Centre of Birmingham, England. Captain Stone is the author of "Hospital Organization and Management," the outstanding British text on hospital administration, and of "Hospital Accounts and Financial Administration," which is used as a standard for hospital accounting in Great Britain.

A court on hospital operation to try the case of "Disturbing Conditions *v.* Correct Procedure" will be presented by the section on mechanical divisions at the convention. A panel of "professional jurors," experts on problems in the power plant, paint and painting, plumbing, laundry service and the care and maintenance of floors will decide the cases brought before the convention. A question box will be provided at the registration desk for the "plaintiffs" to file "suits." The questions will be referred to the "court" and the respective "juror" who is an expert in the field of operation to which the question belongs.

Medical Circulating Library

A circulating library has been created at the Central Maine General Hospital, Lewiston, through a grant of the Bingham Associates in honor of the late Dr. Frederic Henry Gerrish, who was at one time professor of anatomy at Bowdoin College Medical School, Portland. Material in the library, which now contains seventy-five journals, together with a large collection of reprints, will be available to all members of the state medical association.

School Children Contribute

A gift of $500 from the pupils and teachers of the Charles Feilbach School for Crippled Children in Toledo toward a fund for new quarters for the Convalescent Home for Crippled Children was the first gift recorded in a campaign to raise $300,000.

1,200 Nurses Imported for N. Y. C. 8-Hour Day

To put the eight-consecutive-hour day into effect in New York City hospitals by July 1, it was necessary to import 1,200 additional nurses according to Dr. S. S. Goldwater, commissioner of hospitals.

Commissioner Goldwater declared that to obtain the 1,200 additional nurses the city advertised extensively. Discrimination against registered nurses from other states was abolished in the effort to bring the nursing staff up to the required quota. Formerly, such nurses were employed by the city only as nurse attendants although they might have been fully qualified and actually doing regular nursing duty.

At first Doctor Goldwater predicted that the eight-hour-day law would be delayed until "well past July," because of the shortage of nurses in municipal hospitals, and stated that he intended to urge the board of health to issue a "declaration of imminent peril" as a means of obtaining temporary suspension of the law.

"It may take us a few weeks to put the new schedule for nurses into complete operation throughout the city, but we expect to be ready to start on July 1," Doctor Goldwater said later.

Commission Recommends Regional Councils

The long awaited report of the commission appointed by the British Hospitals Association to study the present position and future policy of the voluntary hospitals was received in this country recently.

Heading the list of recommendations is that the country be divided into hospital regions, each of which should have a hospital council to correlate hospital work with the needs of the region and to raise funds for the benefit of all hospitals in the area.

Uniform hospital accounting, financial aid from government funds for the care of indigent and other government wards, extension of contributory (group hospitalization) plans to all areas, full utilization of existing bed facilities, and provision of auxiliary hospitals to relieve the load on main hospitals are some of the recommendations of the commission.

The commission, which was headed by Viscount Sankey, urged that no more special hospitals be built and that existing special hospitals be affiliated with general hospitals. Adequate provision in the voluntary hospitals for paying patients was urged. Restrictions on out-patients were suggested.

Payment to the doctors on the medical staff was recommended except when they are on the staffs of teaching hospitals or of hospitals having a considerable number of pay beds.

Another recommendation of special importance was that a well organized publicity department be established on a national basis to advance the interests of hospitals. This department should be under the direction of a person of training and experience.

Finally the commission urged that full cooperation be established between the voluntary and the government hospitals and that the proposed regional hospital councils have members representing local government authorities.

Reelects Officers

H. H. McGill, administrator of the Columbia Hospital, Columbia, S. C., was reelected president of the South Carolina Hospital Association meeting in Columbia recently. Other officers reelected also were Charles H. Dabbs, administrator of the Tuomey Hospital, Sumter, secretary-treasurer, and Mrs. Byrd B. Holmes, Greenville General Hospital, Greenville, vice president. The South Carolina association will be hosts to the 1938 Tri-State Conference.

Catholic Hospital Association Endorses Group Hospitalization at Chicago Meeting

A definite change of policy toward group hospitalization plans was effected by the Catholic Hospital Association meeting in Chicago the week of June 14. After several years of opposition to such plans, the association formally recognized the great advancement in present day free choice, nonprofit plans and declared that it desires "to encourage its members to join such plans as conform" to certain standards.

The standards suggested were similar to those adopted by the American Hospital Association. The resolution, which was carried unanimously, suggested that Catholic hospitals study such plans carefully to be sure they are adaptable to the community and to the particular hospital.

A second resolution called on Catholic hospitals to foster relations with their personnel on a basis of just economic exchange, fairness, mutual cooperation and charity. In presenting the resolution, Father Alphonse M. Schwitalla, president, said that "there is no sense in taking an attitude of opposition to unions. We should face the issue with a stout heart. The good will of our employees is more important to us today than ever before." He declared, also, that hospitals cannot permit strikes or work stoppages.

The resolution as adopted stated that hospitals "cannot be unsympathetic to the desires of their employees for collective bargaining but the attention of both hospitals and employees is directed to the fact that any interruption of service implies moral and social consequences more important than economic matters."

The Catholic Hospital Association aligned itself behind the work of the American College of Hospital Administrators and endorsed the plan for the education of hospital administrators. The association approved the idea that for the future a master's degree should be the minimal requirement for a hospital administrator and that this degree should be granted only by universities that have a medical school and a hospital and can offer or arrange internships in hospital administration.

The attitude of the association toward national studies affecting hospitals was expressed in a resolution that stated that the association will not cooperate in a national study unless it has been instrumental in formulating the policies of that study.

The association's previous stand against health insurance was reaffirmed, although in a recent encyclical on aetheistic communism the Pope had favored health insurance in the following words: "Nor would social justice be done . . . unless opportune councils were initiated for their [the wage-earner's] convenience, by which they, either through public or private insurance, were able to make provision for their old age, their sickness and their employment."

The meeting was also marked by further advance toward the accrediting program for Catholic schools of nursing. Sister M. Henrietta of St. Mary's Hospital, Kansas City, Mo., chairman of the Council on Nursing Education for the United States, announced that a committee of four to six examiners is to be set up to visit and evaluate all Catholic schools. It is expected that the council, the examiners and the members of an advisory committee representing such related fields as education, hospital administration, social service and dietetics, will meet some time in the fall to spend three or four weeks in continuous, intensive study of the whole field of accrediting. Final responsibility for the accrediting of the schools will rest ultimately with the executive board of the Catholic Hospital Association.

The convention was one of the most successful in the history of the association with a registration of more than 2,500 delegates, guests and exhibitors. All of the officers were reelected.

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CHICAGO NEW YORK

Hartman Succeeds Lutes as A. C. H. A. Secretary

Gerhard G. F. Hartman has been chosen as the new executive secretary of the American College of Hospital Administrators to succeed J. Dewey Lutes, who has been executive secretary since the college was founded. Mr. Lutes asked to be relieved of his office last year, but was persuaded to stay with the promise that a full-time executive would be appointed within the year.

Mr. Hartman, who assumed his new duties on July 1, will devote full time to the college and to its various interests including the course in hospital administration at the University of Chicago. This course, it is understood, is to be taken over by Dr. Arthur C. Bachmeyer, director, University of Chicago Clinics. Dr. Michael M. Davis, who has directed the course since its establishment three years ago, recently moved his office to New York City.

Mr. Hartman has both a bachelor's and a master's degree from the University of Buffalo, where he majored in economics and business administration. He is now a candidate for a doctor's degree in hospital administration from the University of Chicago, the first person in the United States, so far as is known, to have been granted

Fernand De Gueldre

Gerhard G. F. Hartman

this degree. While at Buffalo Mr. Hartman prepared a master's dissertation on linen control systems in hospitals of various sizes and was assistant teacher in marketing and business law. His doctoral dissertation at Chicago is on hospital malpractice insurance.

Mr. Hartman was financial statistician at Columbia-Presbyterian Medical Center from June, 1932, to December, 1933, and special senior investigator with the United States Treasury Department for the credit survey of the Cleveland Federal Reserve District in 1934. For the past two years he has been Julius Rosenwald Fund fellow in hospital administration at the University of Chicago and during the past year has been teaching assistant to Dr. Michael M. Davis in the hospital administration course there.

Dr. French Sells Hospital

Dr. J. Rollin French, who for twenty years has operated the Golden State Hospital, Los Angeles, recently sold that institution to a former partner, Dr. C. E. Early. Doctor French will devote his time to private practice, specializing largely in consulting practice in insurance medical problems.

Convert Hospital Basement

The basement of Mary M. Packer Hospital, Sunbury, Pa., will be converted into modern hospital quarters, with waiting room and other facilities approached by a subgrade entrance. On the first floor, the change will make possible twelve more private rooms.

Knickerbocker Hospital Marks 75th Anniversary

Knickerbocker Hospital, New York City, founded in a tent in old Manhattanville during the Civil War, marked its seventy-fifth anniversary on May 20. President Roosevelt added his congratulations to those of other friends of the hospital who gathered at a celebration luncheon in the Hotel Astor where Dr. Nicholas Murray Butler, president of Columbia University, was the principal speaker. A message of greeting also was received from Governor Lehman of New York State.

The May luncheon marked the beginning of an effort to raise $150,000 for a new clinic building and other improvements at the hospital.

Arkansas Hospital Association Admitted to Midwest Group at Colorado Springs

The Arkansas Hospital Association applied for and was granted full membership in the Midwest Hospital Association at the recent meeting in Colorado Springs on June 10 and 11, thus bringing the membership in this regional group to five. The other members are the state associations of Colorado, Kansas, Missouri and Oklahoma. In number of states represented the Midwest association is now one of the three or four largest in the country.

A special feature of the session was a round table discussion on the place and activities of the American College of Hospital Administrators, conducted by J. Dewey Lutes, executive secretary of the college, and E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis.

Firmness in demanding payment from accident cases when the patients can afford to meet the costs of their care was recommended by Dr. E. T. Olsen, medical director, University and Crippled Children's Hospitals, Oklahoma City, Okla. "It is a common practice today for the public and the police to bring accident cases to the hospitals where they will receive treatment and where they find it easy to unload their burden," he said. "A firm attitude regarding payment for service and the immediate removal of non-paying patients who can be moved with safety will save you much grief without any loss of public respect. Perhaps I may seem a little hard-boiled, but what I have said is based on many years of experience. My observation has been that many institutions who were lax in this respect were on the border line of bankruptcy and unable to pay for the very supplies used in the treatment of these accident cases, to say nothing of meeting their pay rolls."

Both favorable and unfavorable factors in the present situation of voluntary hospitals were pointed out by Arthur M. Calvin, president, American Protestant Hospital Association, in discussing "Reconstruction Problems." Listed as favorable factors were increased occupancy, reduction of hospital indebtedness, better public relations programs and growth of group hospitalization. On the other side, Mr. Calvin listed the dissatisfaction of employees with wages and hours, the shortage of nurses, the growth of malpractice suits and the increasing cost of malpractice insurance, the development of improvised hospitals and nursing homes by unemployed nurses, the need to raise hospital standards, the reduction in gifts and the competition by government hospitals.

A warning was sounded by Mr. Calvin that while no provision has yet been made for hospitalization of the beneficiaries of old age pension acts, hospitals should develop an adequate plan for their care immediately if they wish to avoid a repetition of the experience they have had with the hospitalization of veterans.

The relations of hospitals and their employees were discussed by Dr. Joseph C. Doane, editor, The MODERN HOSPITAL, who also conducted an administrative round table conference and spoke on "Dietetic Dilemmas."

T. J. McGinty, superintendent, Southeast Missouri Hospital, Cape Girardeau, Mo., was elected president of the Midwest Hospital Association, Dr. E. T. Olsen was chosen as president-elect and Florence King, Jewish Hospital, St. Louis, was reelected executive secretary and treasurer.

Short Talks on Timely Subjects Feature Panel Discussions of New Jersey Meeting

Variety was injected into the program of the convention of the New Jersey Hospital Association held in Atlantic City, through an afternoon of panel round table discussions. Speakers were given ten minutes to answer given questions on subjects assigned them, and an additional five minutes to answer questions from the floor.

Discussing oil *versus* coal in hospital heating, Charles Lee, superintendent, Homeopathic Hospital, East Orange, N. J., emphasized the flexibility of oil, also its greater hazards. Its advantages are more manifest, he feels, in large institutions than in small plants. In discussing elevator maintenance, Mr. Lee favored the hospital servicing its own elevators if it was prepared to do so. Sound *versus* sight in call systems was another topic he touched upon. The audible paging system produces quicker response, he believes.

What an R.N. Costs

It costs anywhere from $1,100 to $2,160 to put a nurse through a three-year training course, including maintenance, according to Margaret Ashmun, R.N., director of nurses, Orange Memorial Hospital. Whether or not there is a field for properly trained practical or household nurses, Miss Ashmun believes the nursing profession is not yet ready to say, but indicated an interest on the part of nursing groups in making a study of the situation.

Importance of the dietitian being at the receiving door when goods arrive was emphasized by Sarah D. Benedict, chief dietitian, Presbyterian Hospital, Newark, N. J. Asked to indicate what should be the ratio of dietitians to average number of patients in a general hospital when the dietitian's duties include purchasing, Miss Benedict's answer was one to approximately one hundred patients.

Special precautions necessary in handling oxygen therapy were discussed by Dr. Albert G. Markel, Paterson, N. J.

The modern hospital cannot afford not to publish an annual report, is the feeling of Le Roi A. Ayer, superintendent, Cooper Hospital, Camden, N. J. Among numerous advantages it helps contributions. He also advises adding new names to the mailing list each year to attract the interest and attention of prospective subscribers, including high school principals. The report should be more concise, with financial statements condensed and liberal use made of illustrations. July is a good time for distribution.

The organization of a junior women's auxiliary was outlined by Doris Harvey, president, Junior Aids of Mercer Hospital, Trenton, N. J., and Frances Holbrook, director of social service, Orange Memorial Hospital, talked on the contribution which the hospital social service worker can make to the field of research. Answering the question of what is a reasonable finished cost per hundred pounds (dry) of washing those linens which do not require hand pressing, S. Frank Roach, superintendent of laundry, Medical Center, Jersey City, explained that it probably would run something like 65 cents per hundred pounds.

"More than ever before it is urgent that the hospital trustee familiarize himself with all aspects of his hospital's many-sided problems that he may wisely formulate its policies," is the opinion of Charles Neergaard, hospital consultant, New York City. Mr. Neergaard ventured a suggestion on how the hospital can get its cost, and how the doctor can get something for his efforts.

"Extend the group prepayment plan with a $6 charge for ward care *versus* the present $10 for semiprivate. Limit the new classification to the medically indigent and surround it with every safeguard for medicine. From actuarial experience the service organization should be able to pay the hospital $5 a day and the hospital to care for ward patients at $4, the extra dollar going into a medical fund from which the doctor should receive an average of $10 for each case."

Other speakers were: Dr. Haven Emerson, who talked on planning for health requirements in a metropolitan area; Dr. E. H. L. Corwin, whose subject was the trustee and the administrator; Dr. Claude W. Munger, president, American Hospital Association, and Dr. Bert W. Caldwell, executive secretary, American Hospital Association.

Miss Hamilton for President

Eleanor E. Hamilton, Presbyterian Hospital, Newark, succeeds Edgar C. Hayhow, superintendent, Paterson General Hospital, as president, and Dr. Edward Guion, Atlantic County Hospital, Northfield, N. J., becomes president-elect.

Coincident with sessions of the New Jersey Hospital Association, the tenth annual convention of the New Jersey Occupational Therapy Association was held, also a luncheon meeting of the New Jersey State Dietetic Association, which was addressed by F. Stanley Howe, superintendent, Orange Memorial Hospital.

South Dakota Hospitals Benefit Through Beer

High point in the meeting of the South Dakota Hospital Association at Aberdeen on June 9 and 10 was announcement that $180,490 was distributed from state beer revenues to the counties of the state to be disbursed under the supervision of the county commissioners and so much as is necessary for that purpose to be used primarily for the hospitalization of the indigent. The county allocations for 1936 ranged from $1.78 to Armstrong county to $13,715.45 to Minnehaha. Armstrong has no hospitals while there are five in Minnehaha.

The use of beer revenues for hospital care was originally fought by the brewers but now they are glad to be able to tie their public relations program to the hospital. "Drink beer and provide hospital care for the sick poor."

Plans for a group hospitalization service in Sioux Falls are being carefully considered with considerable thought given to a statewide plan. E. A. Van Steenwyk, executive secretary, Minnesota Hospital Service Association, described the work of his organization and some of its future plans as outlined elsewhere in this issue. Leila Givens, Brookings, reported on a survey of nurses' training schools.

Officers elected at the meeting were: P. J. Blegen, Peabody Hospital and Clinic, Webster, president; C. M. Austin, Sioux Valley Hospital, Sioux Falls, vice president; George Kienholz, St. Mary's Hospital, Pierre, secretary-treasurer, and the Rev. Sr. Monica, St. Joseph's Hospital, Mitchell, and the Rev. Sr. Flavia, Sacred Heart Hospital, Yankton, trustees.

New York Department Has New Nurses' Aid School

Inauguration of an institute for teachers of men and women hospital attendants, to instruct nurses' aids in "doing the common task in an uncommon manner," by the New York City Department of Hospitals is expected to make more economical use of the eight-hour day which becomes effective July 1. Fully trained nurses will be relieved of the routine tasks which the attendant group may perform, and time saved for the hospitals in that manner. Edna Plambeck, assistant director of the division of nursing of the Department of Hospitals, presided over the first meeting. Speakers were Dr. Adam Eberle, general medical superintendent; Mary Ellen Manley, director of nursing, and Frances West, all of the Hospitals Department, and Mrs. E. S. Epstein of the Emergency Relief Bureau.

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Press and Public Confused by Action of A. M. A. Regarding Government Medicine

By Alden B. Mills

Considerable confusion apparently exists in the newspapers and therefore in the public mind over the action taken by the American Medical Association last month on the matter of a public system of medicine. Press headlines indicated that the association had moved rather far toward endorsement of an extension of government responsibility, although the actual reports from correspondents were more guarded in statement.

The issue was presented by Dr. Samuel J. Kopetzky representing the New York State Medical Society. New York proposed adoption of the principles that (1) "the health of the people is a direct concern of government and a national public health policy directed toward all groups of the population should be formulated," with the advice of organized medicine expressed in a special commission authorized for this purpose; (2) "that adequate medical care is an essential element of public health and local, state and federal governments need to supplement present efforts of the medical profession to provide it," and (3) "that the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches for their solution."

As steps in carrying out these principles the New York doctors proposed: (1) the extension of public health services, federal, state and local; (2) adequate medical care for the indigent, the costs to be met from public funds, and (3) public subsidies for medical education, research and laboratory and diagnostic services in hospitals. The use of existing private institutions approved by the local medical professions was urged as well as the planning and direction of any such work by experts nominated by the medical profession. Finally the New York group denounced compulsory health insurance and urged the consolidation of federal health and medical activities in a separate department.

After much discussion, the delegates reaffirmed the association's desire for a separate national department of health, its "recognition of the primary importance of public health," and opposition to both voluntary and compulsory health insurance.

The association stated that doctors were "ready and willing to consider with other agencies ways and means of meeting the problem of providing medical services . . . for all requiring such service and not able to meet the full cost thereof," but insisted that these are local and state, not national, problems. It also stated that the "records, source material and experience of the association . . . are at the service of agencies contemplating the development and operation of plans for medical care." The bureaus, councils and committees of the association were directed to continue their studies of distribution of medical service. Finally the association reaffirmed "its willingness on receipt of direct request to cooperate with any governmental or other qualified agency. . . ."

While there is little or nothing in the action taken which can be instanced as a victory for the liberals over the conservatives, nevertheless competent observers declared that the thinking of the association did actually move toward a franker acknowledgment and more realistic approach to the problem of providing adequate medical service.

A report on group hospitalization was adopted declaring that such service should be limited to room, bed, board, nursing, facilities ordinarily provided by hospitals and routine medicines, without including any professional or partly professional services.

On the subject of contraception the doctors decided: (1) to make clear to physicians their legal rights in relation to the use of contraceptives; (2) to investigate materials, devices and methods of contraception to determine their effects and to publish the results of such investigations, and (3) to promote thorough instruction in medical schools in the various factors pertaining to human fertility and sterility, "due attention being paid to their positive as well as to their negative aspects."

Dr. Irvin Abell of Louisville, Ky., was chosen as president-elect and Dr. J. H. J. Upham of Columbus, Ohio, was installed as president. The retiring president, Dr. Charles Gordon Heyd of New York City, was elected to membership on the Council of Medical Education and Hospitals to succeed Dr. Charles E. Humiston. The meeting was the largest in the history of the association with a total registration of 9,764 doctors. The next meeting will be held in San Francisco.

Ground Broken for New York's New Memorial Hospital

Ground for the new twelve-story and penthouse building of Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City, has been broken and it is hoped to have the structure ready for occupancy within a year and a half.

The new building will replace the present institution and will cost between $3,000,000 and $3,500,000. It adjoins the Rockefeller Institute for Medical Research, the New York Hospital, and Cornell University Medical College with which it is affiliated. The site was given by John D. Rockefeller, Jr., and a year ago the General Education Board made a grant of $3,000,000 toward the erection and equipment of the institution.

The new building will provide at the outset for 160 beds, with provision for great expansion. It has been designed by James Gamble Rogers and Henry C. Pelton, associated architects.

PENNIES PAY FOR REPAIRS

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Let's look at the record: On May 15 Hugo J. Stadick, Chief Engineer of the Loretto Hospital, New Ulm, Minn., wrote us "We have 22 valves installed an average time of 6 years and the cost per valve for the 6 year period has been 8c for parts."

Walter W. Bird, Chief Engineer of the Stevens Hotel, the largest in the world, reports the cost per valve for maintaining 3600 valves for seven years to be 1½c a year.

At the State Hospital, Warm Springs, Montana, a total of $2 has been spent on repair parts for 100 valves in eight years, or a quarter of a cent a year per valve!

The Oxford Hotel, Denver, replaced other flush valves with Sloan in 1931. Nothing has been spent for upkeep since that time.

At 35 E. Wacker Drive in Chicago, an office building, the valves have been touched only once in eight years.

Kelly Brothers Company of Minneapolis report no repair cost whatever on their valves installed in December, 1930.

These reports are typical of the comments of Sloan users who keep a record of their maintenance expense. If you are not now enjoying the low-cost performance of Sloan Flush Valves, you can modernize your equipment at a substantial profit.

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Golf, Personnel and Other Problems Engage Pennsylvania Administrators

This year Pennsylvania hospital administrators chose the mountains for strength and inspiration—a happy selection in the opinion of many who enjoyed the fishing and golfing at Buck Hill Falls, Pa., when not otherwise engaged in business sessions or inspecting the attractive array of exhibits lined up in the famous Inn. Total attendance, while not as large, perhaps, as in previous years in Philadelphia or Pittsburgh, made up in interest what it lacked in size.

Three days in all were devoted to a program chock full of brief snappy talks—no longer than ten minutes many of them, and invariably followed by discussions in which participation was keen and opinions varied. As part of the business routine, Melvin L. Sutley, Delaware County Hospital, Drexel Hill, relinquished the duties of president to Mary B. Miller, Presbyterian Hospital, Pittsburgh. It was with much regret, too, that members of the association learned of the resignation of John N. Hatfield, administrator, Pennsylvania Hospital, Philadelphia, as executive secretary. Mr. Hatfield, however, becomes president-elect, and Harold T. Prentzel, Friends Hospital, Philadelphia, is the new secretary.

Elmer E. Matthews, superintendent, Wilkes-Barre General Hospital, continues as treasurer, and Roger A. Greene, Pottsville Hospital, Pottsville, and Mr. Sutley were appointed to the board.

Guests From Outside State

Many well known figures in the hospital field attended. Dr. Claude W. Munger, president of the American Hospital Association, not only described the activities of the national association from his own personal experiences in journeying about the country, but conducted a round table. Another guest was Graham L. Davis, director, hospital section of the Duke Endowment, Charlotte, N. C., who outlined the proposed membership structure of the American Hospital Association.

Dr. C. Rufus Rorem, director, committee on hospital service, American Hospital Association, described recent developments in hospital care insurance.

In the opinion of Doctor Rorem, hospital care will be budgeted some day at one cent a day, "and it will be good care." "The plans that have been most successful," he pointed out, "are those that have charged the lowest rate. The most liberal plans are those that grow fastest. Any such plan should be based on community needs—not on hospital needs."

Following Doctor Rorem's talk on the subject, several administrators described briefly their own individual plans. A. R. Hazzard, superintendent, Easton Hospital, Easton, explained how group insurance has worked out in his institution. Others giving their experiences were: Sister M. Irenaeus, superintendent, Providence Hospital, Beaver Falls; James R. Mays, executive director, Abington Memorial Hospital, Abington; Louis C. Trimble, superintendent, Adrian Hospital, Punxsutawney, and Abraham Oseroff, director, Montefiore Hospital, Pittsburgh.

Antidote for Gossip

In discussing gossip and rumors in relation to hospital goodwill and personal cooperation, H. G. Fritz, Conemaugh Valley Memorial Hospital, Johnstown, urged his listeners not to wait for things to happen, but to make them happen. Development of better morale among the personnel is the best antidote for destructive gossip, he contends. Incidentally, Mr. Fritz keeps a box at the front door of his hospital for comments, criticism and suggestions. He also follows up each patient after discharge with a personal note accompanied by a business reply envelope.

Too often the hospital budget is regarded merely as a financial gadget adapted only to large and complicated organizations, whereas it constitutes merely sound business practice. R. F. Hosford, Bradford Hospital, Bradford, Pa., made this clear.

Much interest centered on a presentation of nursing service. This took the form of an explanatory dialogue on how the proposed curriculum will affect nursing service. The discussion that followed raised many questions on the practicability of the plan from the standpoint of hospital administration. Those participating were: Alma M. Troxell, Oil City General Hospital, Oil City; Mrs. Vera Brandt, director of nursing, Bradford Hospital, Bradford, and Mrs. Alberta Trunck, educational director, Warren State Hospita, Warren.

The sessions closed with a round table conducted by Dr. Joseph C. Doane, Jewish Hospital, Philadelphia, and editor, The MODERN HOSPITAL.

OIL CITY, PA.—A deep therapy x-ray machine has been installed at Oil City General Hospital by Mrs. George N. Reed as a memorial to her husband who was a member of the hospital's board of directors for many years.

BEQUESTS AND GIFTS

NEW LONDON, CONN.—The Lawrence and Memorial Associated Hospitals have been bequeathed $400,000 under the will of the late Virginia Palmer, to provide a building and an endowment. This fund probably will be used for a building housing a tumor clinic and x-ray therapy departments, and accommodations for chronic patients, according to K. M. Prindiville, superintendent. No immediate action is anticipated.

MOULTRIE, GA.—W. C. Vereen, president of the Moultrie Cotton Mills, has agreed to donate $27,500 toward erection of a $50,000 city-county hospital here.

INDIANAPOLIS.—A gift of $10,000 was received by the Methodist Hospital with the stipulation that the money be used to help deserving young women obtain a nursing education, preferably those who wish to enter DePauw University for the five-year course. The money was given by Mrs. Jennie Keller of Winamac, Ind., and preference will be given to students from this locality. Loans are to be returned without interest after graduation.

LEXINGTON, KY.—Leo J. Marks recently donated $25,000 for the construction of a new wing to the Tuberculosis Sanatorium. The new building will house colored tuberculosis patients who have been living in frame buildings surrounding the hospital.

BOSTON, MASS.—With the construction and equipment of a 100-bed hospital as the objective, William Bingham, 2nd, of Bethel, Me., and Miami Beach, Fla., has presented the Boston Dispensary with a gift of approximately $500,000. The hospital will be a part of the Boston Dispensary and will be named in honor of Dr. Joseph H. Pratt, who for the past ten years has done outstanding work at the dispensary. Mr. Bingham has not only agreed to give funds for the construction and equipment of the hospital but also will defray deficits incurred in its operation so that the Community Federation of Boston will not be asked for funds.

MIDDLEBORO, MASS.—The bequest of Mrs. David G. Pratt to St. Luke's Hospital, of about $60,000, is to be used to construct an addition to the hospital. Mrs. Pratt's bequest provides that none of the fund should be used for repairs or renovations of the existing structures.

PHILADELPHIA, PA.—Pennsylvania Hospital was awarded $21,000 from the estate of the late Emily F. Dawson, to endow free beds in memory of herself, her mother and her sister.

PITTSBURGH.—Shriners' Hospital for Crippled Children, Philadelphia, will share with other charities in the $50,000 estate of Alex H. Patterson.

NEW BUILDING PROJECTS

ANCHORAGE, ALASKA.—Dr. H. R. Stamm, architect for the bureau of Indian affairs at Anchorage, has announced that the government will build a $150,000 hospital during the summer at Bethel, Alaska. Remodeling of the Unalaklet Hospital, construction of a clinic and quarters at Kodiak and hospital buildings at Kanakanak and Tanana will be undertaken later.

OAKDALE, CALIF.—Stanislaus county's new tuberculosis hospital will be built in Del Puerto Canyon, twenty-five miles from Patterson and five miles from the Santa Clara county line at a cost of approximately $60,000, accommodating more than seventy patients.

SAN FRANCISCO, CALIF. — Included in funds approved by the California state assembly for construction of new buildings for the University of California is $1,120,000 for a university hospital in San Francisco.

BALTIMORE, MD.—Construction began June 15 on the $195,000 addition to the Nurses' Home at John Hopkins Hospital.

PETOSKEY, MICH.—A new five-story, fireproof hospital to be known as Little Traverse Hospital, to cost about $175,000, will serve all northern Michigan. Facilities will care for approximately sixty patients. Completion of the building has been set tentatively for October 31, 1937.

KALISPELL, MONT.—Plans have been completed for construction of a $50,000 addition to the Kalispell General Hospital. Of the money, $30,000 is being provided by the Sisters of Mercy who manage the hospital, and $20,000 is to be raised by popular subscription in the community.

BUFFALO, N. Y.—An addition to Buffalo General Hospital, to cost between $125,000 and $150,000, is being constructed to house the surgical department, staff rooms, and twenty rooms for patients. The entire second floor will be devoted to the surgical department, to be one of the most modern and efficiently equipped of any hospital in the country, according to Dr. Fraser D. Mooney, superintendent. Walls of the windowless operating room will be treated to diffuse even light. A new type students' gallery will be built eight feet above the operating table and will be shut off by glass.

RAY BROOK, N. Y.—Construction of a new $479,973 infirmary, designed to add 100 rooms to the New York State Hospital for Tuberculosis, is now under way. The addition to the hospital will include a surgical room, x-ray equipment and solariums.

NASHVILLE, TENN.—Three hundred tons of dynamite have been buried in the entrails of the Vanderbilt University campus and fifty-five hundred cubic yards of stone, and nine thousand cubic yards of earth have been blasted for the excavation of the new eight-story addition to the Vanderbilt Hospital.

RICHMOND, VA.—The cornerstone was laid for a clinic and laboratory building at the Medical College of Virginia. A new heating plant and a laundry have been completed at the college and a dormitory for hospital house staff and senior medical class will be begun soon. The building program as a whole amounts to more than $1,000,000.

ROOSEVELT, UTAH—A new $30,000 Latter Day Saints Hospital will be constructed soon in the Uintah Basin, containing twenty-one beds, two large wards for medical and surgical cases, a maternity ward, delivery room, operating room, several private rooms, kitchen, storerooms and offices.

CHARLESTON, W. VA.—Coal Valley Hospital will soon have a new home. Bids were recently awarded for the construction of the three-story and basement fireproof structure, which will house a clinic and beds for 125 patients.

BELLINGHAM, WASH.—The building that once housed one of the finest hotels on the Pacific Coast has been persented to Whatcom County for use as a hospital, by Mrs. Frances P. Larrabee and her son Charles.

Ground was broken for the new Wesley Hospital, Chicago, on June 18. Thielbar and Fugard, architects, made the design.

Connecticut M.D.'s View Group Hospitalization

The Connecticut State Medical Society is in favor of group hospitalization if administered by nonprofit organizations and excluding any medical services except those customarily rendered by a resident house and intern staff, asserted Dr. Creighton Barker, executive secretary of the society, in addressing the Connecticut Hospital Association at its meeting in Danbury on June 4.

If x-ray and laboratory services are to be included in group hospitalization plans they should also be available on flat rates to other semiprivate patients, Doctor Barker declared. "We are convinced that to allow any medical service to fund subscribers that was not available to nonsubscribers would be a beginning from which there might eventually come an effort to include other professional services."

The advantages of group hospitalization to the hospitals, the public and the medical profession were outlined by Rev. John G. Martin, Hospital of St. Barnabas, Newark, N. J. About 10 per cent of the income of hospitals in the Essex County plan now comes from group hospitalization funds, Mr. Martin stated.

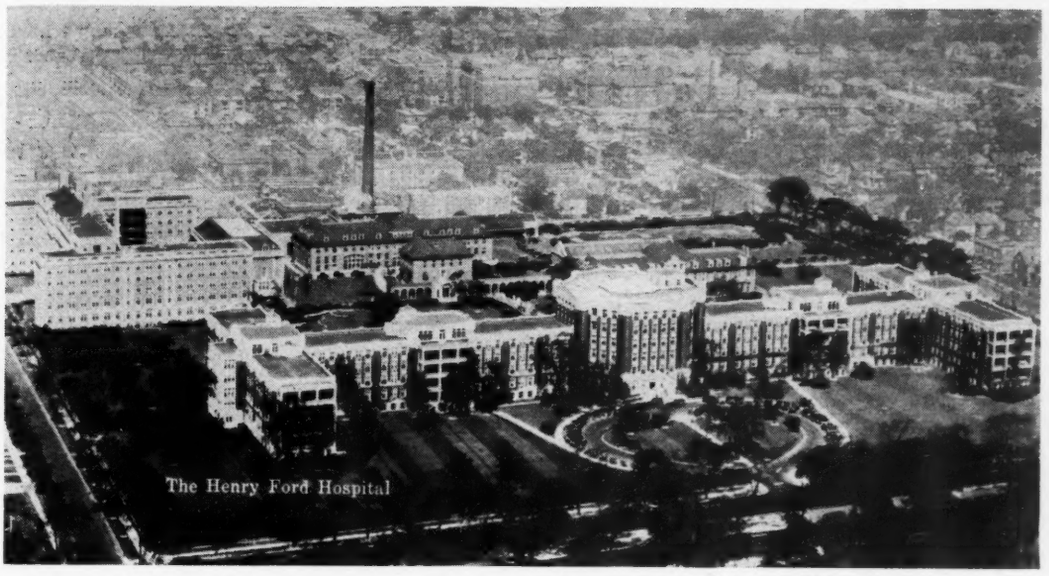
Robert A. Parnall, director, Hospital Service Fund, Inc., New Haven, Conn., also discussed group hospitalization. Mrs. Lucy Abbott Pollock conducted a round table.

Property Bought for Hospital

A seven-acre property owned by the New York School for the Deaf, at Riverside Drive and 165th Street, New York City, has been purchased as a gift to Presbyterian Hospital by an unnamed donor. The property, just south of the Presbyterian School of Nursing on Riverside Drive, has a 640-foot frontage on Riverside Drive, and has been occupied by the school since 1856. The School for the Deaf will move to a seventy-six-acre plot in the Town of Greenburgh, Westchester County, near White Plains, which it bought some time ago.

Establishes Serum Center

The Iowa State Department of Health recently established a serum center in Des Moines and began processing convalescent scarlet fever serum. At regular intervals since September, 1936, clinics have been held in Sioux City, Waterloo, Decorah and Des Moines to obtain blood from convalescent scarlet fever patients. For some time the state department of health has been distributing convalescent serum to physicians through the cooperation of the Samuel Deutsch Serum Center at Michael Reese Hospital, Chicago.



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NAMES IN THE NEWS...

DR. JOE R. CLEMMONS, assistant director at Strong Memorial Hospital, Rochester, N. Y., has been appointed director of the Roosevelt Hospital in New York City. Doctor Clemmons will assume his new duties on August 2.

MILTON M. BERGEY, who retired recently as superintendent of the Washington County Hospital, Hagerstown, Md., has been succeeded by CHARLES J. COTTER of Westfield, N. J.

JEANNE MILLER, R.N., has been named superintendent of the Jersey Shore Hospital, Jersey Shore, Pa., succeeding MRS. EUGENE NAGLE, who resigned recently.

DR. JOHN K. DEEGAN has been appointed superintendent of the new Herman M. Biggs Memorial Hospital near Ithaca, N. Y. Doctor Deegan has been identified with the state division of tuberculosis for more than four years, and has served as acting physician in charge of the Biggs Hospital since it was first opened a few months ago.

DR. J. R. HOWELL, for more than nine years superintendent of the Aiken County Hospital, Aiken, S. C., has offered his resignation to the board of trustees of the hospital.

MRS. DAGMAR EINSPHAR, superintendent of the Baldwin Hospital, Redfield, S. D., for twelve years, resigned recently because of ill health.

DR. EDWIN B. GODFREY, San Bernardino, Calif., has been appointed state health officer of New Mexico to succeed DR. JOHN ROSSLYN EARP, who resigned to become state director of health.

DR. MARION S. LOMBARD, formerly of the U. S. Marine Hospital, Memphis, Tenn., is now at the Marine Hospital, Buffalo, N. Y. DR. EDWIN H. CARNES, of the hospital at Key West, Fla., will succeed Doctor Lombard.

DR. JAMES MORGAN BLAKE is the new superintendent of the Schenectady County Tuberculosis Hospital, Schenectady, N. Y. He succeeds DR. JAMES C. WALSH, who recently accepted the superintendency of the Nassau County Hospital at Farmingdale, L. I. Doctor Blake has been a member of the sanitarium's medical staff for three years.

KATHERINE MCCONNELL, superintendent of Greenville Hospital, Greenville, Pa., for the last five years, has resigned. She was succeeded by MRS. MARY MCBRIDE WIGMORE of the hospital staff.

DOROTHY EDWARDS from the Veterans Administration Hospital, Hines, Ill., was recently transferred to the Veterans Administration Hospital, Indianapolis, and promoted to the position of chief dietitian.

DR. J. H. STEPHENSON, formerly superintendent of the Dallas city-county hospital, succeeds DR. S. B. HARDY as superintendent of Jefferson Davis Hospital, Houston, Tex.

MRS. MARY J. TAYLOR, superintendent of nurses at Alliance City Hospital, Alliance, Ohio, will succeed MRS. DOROTHY MILLER as superintendent of the Wilson Memorial Hospital, Sidney, Ohio.

MRS. ELIZABETH KINGSFORD, superintendent of the Wheeler Hospital, Gilroy, Calif., for the last six years is resigning to accept a position in a larger institution at Chico, Calif.

DR. CHARLES H. HARRIS will take over management of the Methodist Hospital of Ft. Worth, Tex., to act as operating head while proposed improvements estimated to cost $100,000 are being made.

DR. JOHN WYCKOFF, dean of New York University and Bellevue Hospital Medical College, New York City, died suddenly at Bellevue Hospital. Among his many professional affiliations Doctor Wyckoff was a member of the board of administrative consultants of the Department of Hospitals of New York City and on the technical advisory committee on district health administration.

DR. WILLIAM G. TURNBULL, superintendent of the Philadelphia General Hospital since 1928, was given the Strittmatter Award to the physician who has "made the most valuable contribution to the healing art, including remedial measures, surgical or medical" by the Philadelphia County Medical Society for this year.

DR. HERBERT F. GROSS has been elected to the newly created position of medical director of the Harrisburg Polyclinic Hospital, Harrisburg, Pa. Doctor Gross is a charter member of the hospital board and staff and has served as chief surgeon since the organization of the latter.

DR. A. K. HAYWOOD, superintendent, Vancouver General Hospital, Vancouver, B. C., recently was host to the city aldermen at an annual inspection and informal luncheon at the hospital.

DR. H. W. CHAMBERLIN, for nine years superintendent of Kula Sanitarium, at Waiakoa, Maui, Hawaii, died recently at Waikiki from an overdose of sedative. Dr. Chamberlin came to Honolulu in 1927 as director of the bureau of tuberculosis, and in 1928 was appointed superintendent of the Kula Sanitarium, an institution noted for its treatment of tuberculosis.

MARY F. UNDERWOOD, for fifteen years superintendent of the Chenango Memorial Hospital in Norwich, N. Y., died recently.

ANN C. MCBRIDE, R.N., is acting superintendent of the Community Hospital, Beloit, Kan., succeeding the late THERESIA M. NORBERG, R.N., who served six years as superintendent.

MRS. JULIE M. RITZIUS of Beersheba Springs, Tenn., succeeds Mrs. Mary E. Marshall as superintendent of the Rutherford Hospital, Murfreesboro, Tenn.

HELEN BRANHAM, R.N., formerly superintendent of the Ware County Hospital, Waycross, Ga., is the new superintendent of Tupelo Hospital, Tupelo, Miss.

MRS. EDNA K. HUFFMAN, former president, Association of Record Librarians of North America, and record librarian and head of the school, St. Joseph's Hospital, Chicago, on July 6 will become record librarian at the Grant Hospital of Chicago. Mrs. Huffman is planning to conduct a school for record librarians, opening Sept. 15.

MARY LARTER, for seventeen years superintendent of the North Adams Hospital, North Adams, Mass., has presented her resignation to the board of trustees of the hospital. Her successor is JOSEPHINE E. THURLOW.

DR. J. T. NARAMORE will succeed the late DR. C. S. MCGINNIS as superintendent of the State Hospital for Epileptics at Parsons, Kan. Although Doctor McGinnis was forced to resign because of ill health, his death came quite unexpectedly.

MAUD A. MILES, R.N., for five years superintendent and director of the nursing service at New Hampshire Memorial Hospital, Concord, N. H., has been appointed superintendent and director of nursing at Columbia Hospital, Columbia, Pa. Miss Miles is a graduate of the Hartford Hospital, Hartford, Conn.

HENRIETTA GRANT, retired superintendent of the Frances E. Willard Hospital, Chicago, died recently after a long illness. Miss Grant formerly was assistant in Belgium to Edith Cavell, British nurse who was shot as a spy in 1915 by the Germans.

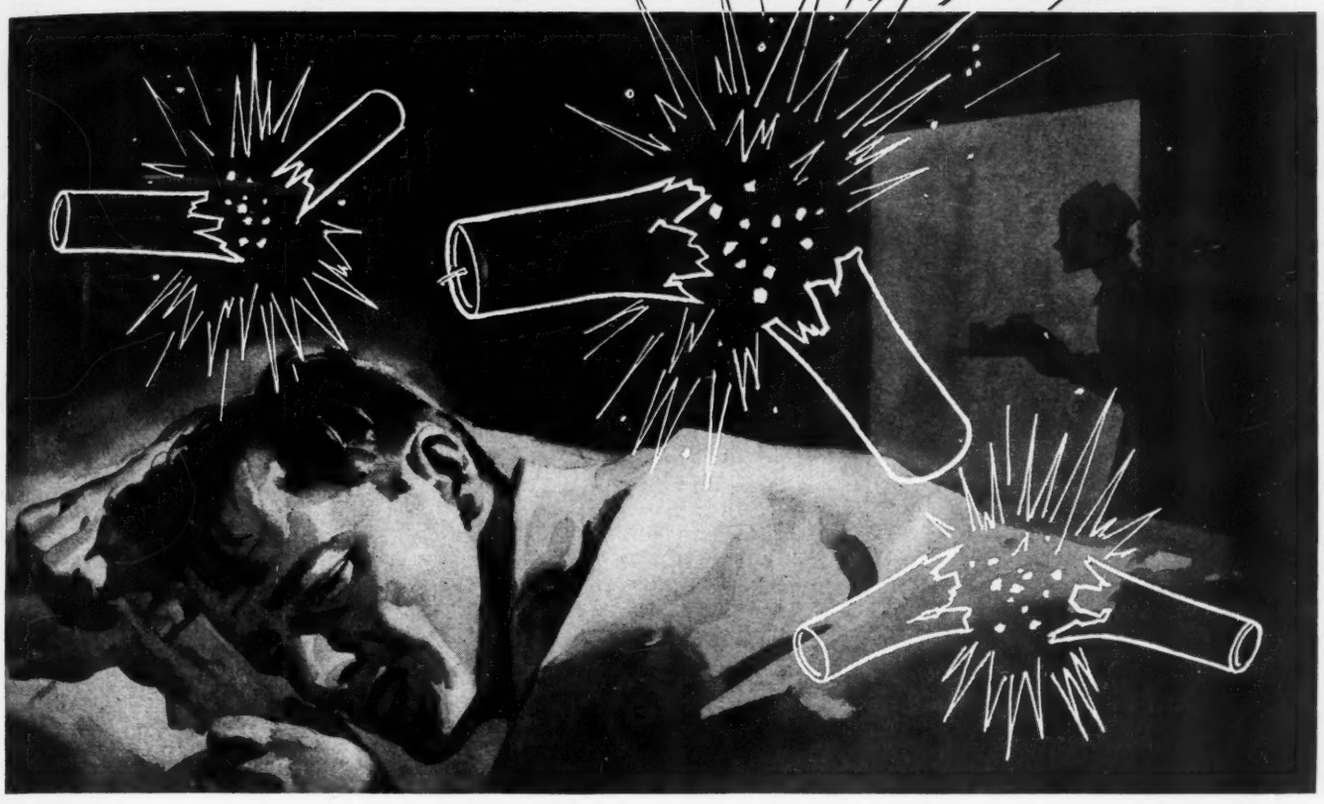
LILLIAN H. ERICKSON on June 15 left her position as medical records librarian at the City Hospital, Akron, Ohio, for a similar position at the Children's Hospital, Milwaukee, Wis.

DR. T. L. HARRINGTON is the new superintendent of River Pines Sanatorium, Stevens Point, Wis.

LUCY H. BEAL, formerly director of nursing at Syracuse Memorial Hospital, Syracuse, N. Y., will succeed CARRIE M. HALL as superintendent of nurses and principal of the school of nursing, Peter Bent Brigham Hospital, Boston.

SIR SQUIRE SPRIGGE, editor of the *Lancet* since 1908, died on June 17 in London. He would have been seventy-seven years old June 22.

Is it "4TH OF JULY" Every day in your Hospital?



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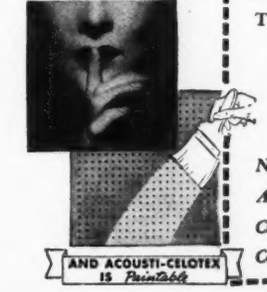

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LITERATURE *in* ABSTRACT • • •

Conducted by E. M. Bluestone, M.D. and Joe R. Clemmons, M.D.

Unknown Quantity

How close does the average executive's idea of the cost of inventory approximate actual costs? From the replies to hundreds of questionnaires we are convinced that inventory costs are an unknown figure.*

The returns brought a wide range of costs. Each one of the following is a definite factor in arriving at the total of inventory costs: interest on capital invested, taxes, insurance, housing, keeping housing in repair, looking after inventory, including handling, taking inventory, clerical costs, deterioration, spoilage, repairs, obsolescence.

Total costs varied from 12 to 35 per cent. Many were high; a greater number were low.

Uncontrolled inventories not only mean the difference between profit and loss, but also may bring about the dissolution of a prosperous business. Inventories accumulate for a variety of reasons. It is a catch-all like the miscellaneous column in a table of figures. Everything that has no definite place elsewhere automatically gravitates to inventory. Another reason is that items that should be junked are figured into the inventory year after year at fictitious values. The most prevalent reason for unbalanced and extravagant inventories is lack of an adequate system of control and inaccurate business forecasts.

*Trundle, George T., Jr.: Your Inventory, Cent. N. Y. Purchaser, 7: 21 (Jan.) 1937. Abstracted by Joe R. Clemmons, M.D.

Occupational Compensation

The committee on standard practices in the problem of compensation of occupational diseases summarizes objectives for the employee and the employer, with suggestions for provisions for such acts.* The employee is entitled to security and prompt payment for medical costs and a predetermined proportion of lost wage during temporary or permanent disability.

Impartial medical care and vocational rehabilitation are essential features of workmen's compensation. It is necessary to avoid laws so burdensome that health requirements will ultimately restrict employment of workers not "physically perfect." The distribution of the economic loss must be equitable among employers, employees and consumers. For the employer there must be protection from expensive and often unjust litigation, with well defined schedules of payments. The medical profession should receive fair recompense and maintain ethical, confidential relationships with employee-patients. Free choice of physicians with the establishment of impartial medical expert boards to determine cash awards should be stressed.

There also is included a list of suggested provisions for workmen's compensation acts, with a view to a fair and equitable administration of the spirit as well as the letter of compensation laws.

*Objectives of Workmen's Compensation for Occupational Diseases, Am. Pub. Health Ass'n Yearbook, 1936-37. Abstracted by J. Masur, M.D.

De-Dusting Coal

Spraying fuels to reduce dustiness is popular.* The characteristics of an ideal agent are: effectiveness for the period of time desired, low cost per ton of fuel, no harmful effects on person, clothing or equipment, lack of odor, no danger of flash-back or evolution of obnoxious gases on firing, freedom of freezing in spraying equipment, no increase in tendency to cake or lump fuels in freezing weather, no effect on the combustion characteristics of the fuel or on the fusion point of the ash and no effect on the storage qualities of coal.

Calcium Chloride Sprays: Calcium chloride solution is used for dustproofing fuel and tends to decrease the fusion temperature of the ash when this temperature is high and to increase the fusion temperature when it is low. No effect on burning or clinkering properties was observed in standard house-heating furnaces. Calcium chloride tends to corrode metal. Electric circuits must be protected from its action.

Miscellaneous Spraying Compounds: Blackstrap molasses in water solution is one, but no information is available as to its cost per ton of fuel effectively treated. A by-product of glycerine manufacture containing salt and soda ash is another but its cost is reported to be high. Petroleum sulphonic acid compounds in water solution have been used. Little information as to costs is available.

Oil Sprays: Oil is applied by spraying from pressure nozzles as coal leaves a conveyor or chute. A thin film over the surface of the coal is essential, but excessive amounts must be avoided. The oil should not give an objectionable odor and should be clean and well filtered. The lower viscosity oils are easier to handle while the higher are more permanently effective. In certain conditions there is danger of an immediate flash-back upon firing. Too much, or uneven distribution of the oil defeats the purpose of cleanliness because of drainage of oil from the fuel. The cost of oil treatment of fuel has been given at four to twenty cents per ton of fuel treated.

*Unsigned, De-Dusting Coal, Heat. and Vent., 34: 44 (May) 1937. Abstracted by Joe R. Clemmons, M.D.

New Sterilizing Control

Inspection of six large hospitals led the author to believe that haphazard methods are generally in use for sterilizing surgical dressings.* He decided to investigate the following questions: (1) What temperature of steam under pressure is required, and how long must that temperature be administered to produce bacteriologically sterile dressings? (2) How can it be proved that the necessary temperature has been reached and maintained for a sufficient length of time? (3) Can steam under pressure penetrate dressings with ease? (4) Does the type of material, the method of packing and the type of container affect steam penetration?

No control could be found which, when placed inside of the drum, would indicate not only the temperature reached, but also how long that temperature was maintained. A mercury thermometer was devised with two platinum points soldered into the lumen, the upper point at 115° C., which was considered the required temperature. When the mercury touches 115° and remains there or at a higher level, an electric circuit is completed which either rings a bell or lights a bulb. In this manner, it is simple to determine when the temperature is reached and how long it is maintained.

Steam penetration varies widely, depending on the method of packing, presence of perforations in the drum, and the type of material to be sterilized. Vacuum sterilizers apparently permit no greater steam penetration than other models.

Perforated drums are necessary. There should be a definite method of packing materials into the drum; the materials must be packed lightly, and the control placed in the center of the drum containing those materials known to give greatest resistance to the penetration of steam. Since these precautions are necessary, it is evident that sterilization of surgical materials should not be entrusted to student nurses.

*Hayes, S. N.: Present Day Methods of Sterilizing Dressings, Brit. M. J., May 1, 1937. Abstracted by A. H. Aufses, M.D.

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MOVES ALL AROUND THE BED
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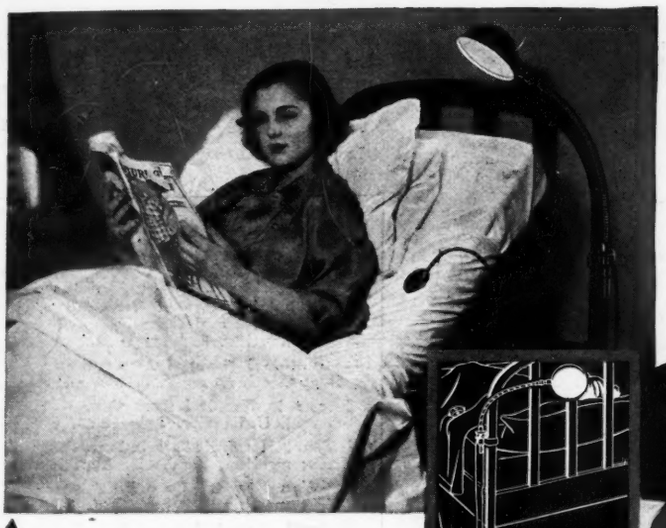

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CLAMPS TO THE SIDE OF THE BED FOR THE PATIENT

Gives ample *localized* light without disturbing others in the ward. Small illustration shows how lamp can be moved behind bed—out of the way when not in use. Clamps furnished to fit all beds.

MOVES TO ANY PART OF THE BED FOR THE DOCTOR. Easily lifted from its clamp, the Greist Hospital Lamp provides intense, concentrated light for examinations or dressings. Can also be used on convalescents' chairs.

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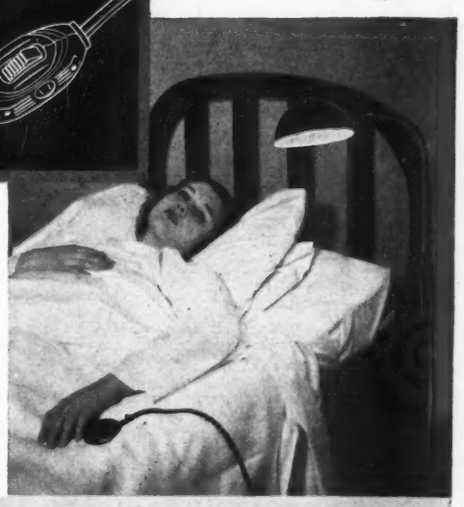

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READER OPINION • • • •

Costs Desired

Sirs:

We are a subscriber to your publication The MODERN HOSPITAL, and thought perhaps that you might be able to supply us with information covering comparative yearly costs of maintenance of institutional buildings on a square foot of floor space area basis.

Rancho Los Amigos, a Los Angeles County charitable institution is comprised of 540 acres of land, approximately 295 of which are used for general agricultural purposes; the balance, or 245 acres comprise the institution's physical plant. The buildings include 263 separate units which vary widely in type of construction from corrugated iron hay sheds to frame, stucco, brick, and reenforced concrete fireproof and earthquakeproof units. The buildings range from seven to thirty years old. There are 832,000 square feet of floor space area involved in the combined total of institutional buildings. We have a complete record of maintenance costs on all of these buildings segregated as to classification or type. The information we desire is the building maintenance cost per square foot of floor space area applicable to some other institution which would be comparable to Rancho Los Amigos. This is desired so that we may check on our maintenance costs.

If you are unable to supply the data requested from your files, will you please secure it for us if possible, or place us in touch with other institutions comparable to Rancho Los Amigos where the information desired may be obtained.

WILLIAM R. HARRIMAN,
Superintendent.

Rancho Los Amigos,
Hondo, Calif.

Hobbyists, Attention!

Sirs:

The New Jersey Hospital Association is acting in the capacity of host to the American Hospital Association at its meeting in Atlantic City this fall and Edgar C. Hayhow, president of the New Jersey Hospital Association has asked me to accept responsibility for the hobby exhibit. It is hoped that this section will prove popular and interesting but, of course, this depends entirely upon the number and type of exhibits.

I wonder if you would be willing to run an item in an early issue of The MODERN HOSPITAL concerning this feature, possibly referring to the interest evidenced in last year's hobby show at Cleveland, Ohio, and asking that any administrators or others working actively in hospitals, who have a hobby which they would be willing to exhibit, communicate with me.

Every effort will be put forth to make this exhibit as interesting as possible and an attendant will be on duty to care for the exhibits and be of assistance to both the exhibitors and visitors.

O. N. AUER,
Director.

Monmouth Memorial Hospital,
Long Branch, N. J.

Robinson-Patman Act

Sirs:

Receipt is acknowledged of your letter of June 3, 1937, advising that information has come to you that a hospital "has been cited by the Commission under the Robinson-Patman Act for accepting a discount larger than is warranted by its volume of business on the item involved."

Up to this time no complaint has been issued by the commission charging violation of the Robinson-Patman Act in connection with sales of goods to any hospital. It may be that your inquiry has reference to a preliminary investigation of alleged violations of the Robinson-Patman Act by a pharmaceutical manufacturer through sales to hospitals at prices less than those charged other customers. However, it is not the practice of the commission to make public any information with respect to informal investigations and specific information in any proceeding is available only after a formal complaint has been issued by the commission.

In connection with your inquiry as to procedure which a hospital may follow to avoid charges of violation of the Robinson-Patman Act through the receipt of a discrimination in price under the terms of the Robinson-Patman Act, there is enclosed a pamphlet containing the text of that Act, together with extracts from its legislative history indicative of the scope and purpose of the law. Your attention is particularly invited to the language of Subsection (f):

"That it shall be unlawful for any person engaged in commerce, in the course of such commerce, *knowingly* to induce or receive a discrimination in price which is prohibited by this section."

JAS. A. HORTON,
Chief Examiner.

Federal Trade Commission,
Washington, D. C.

No Provision Made

Sirs:

Acknowledgment is made of your letter of June 2 in which you ask whether or not voluntary nonprofit hospitals, which are exempt from the unemployment and old age provisions of the Social Security Act, can by voluntary action bring themselves and employees under the provisions of the Act.

The Social Security Act makes no provision for voluntary inclusion of employees in employment specifically excluded under the Unemployment Compensation and Old Age Benefit Sections of the Act.

ROBERT HUSE,
Associate Director,
Informational Service.

Social Security Board,
Washington, D. C.

Unfortunate Oversight

Sirs:

We note in the May, 1937, issue of The MODERN HOSPITAL, page 76, your article on the new laundry for the Monmouth Memorial Hospital, and since we were the architects who planned and designed this building and layout we were much interested in the same. We were disappointed that you had not noted that we were the architects for the same and feel that you must have known this fact since the floor plan seems to be a reproduction of one of our drawings.

EPPIE & KAHRS,
Architects and Engineers.

Newark, N. J.

Laundrymen Organize

Sirs:

Following the successful example set by the laundrymen of New York, Washington and Philadelphia, institutional laundrymen of Massachusetts have organized for the purpose of education in laundry science. Lectures on various phases of laundry work are to be given at their monthly meetings and problems are to be discussed in open forum.

The expense of this association is to be borne entirely by the members of the organization by means of monthly dues. The actual membership consists of superintendents and managers of institutional laundries of Massachusetts. These members carry out the business of the association through their officers and board of directors while all laundry employees interested in the lectures are entitled to attend the forums.

The Institutional Laundrymen's Association asks for the cooperation of superintendents of all institutions of Massachusetts so as to make the association the success that they so much desire. The association officers wish that their organization might be indirectly sponsored by institution superintendents insofar as they might encourage their laundrymen to attend the meetings of the association when it is possible for them to do so.

Many institutions do not employ the services of an experienced laundryman and their laundry is under the supervision of some other department. The washman, extractorman or porter in this type of laundry is privileged to attend the educational functions of the association and may join as an associate member if he so desires.

It is the belief of members of the association that their efforts to improve their knowledge of science and technique in laundry procedure will be reflected in a definite way in the service rendered to their institutions. They feel that by educating themselves in their chosen work they will increase respect for their positions and banish chances of misunderstanding bred from the lack of scientific knowledge on the part of the laundryman.

Each laundryman has in the past followed his individual process of self-education derived almost entirely from experience that could be acquired only over a long period of time. This opportunity for an organized system of education is a welcome innovation to laundrymen of the state.

For the success of this ambitious organization the association needs the help and understanding of every institution superintendent and the ultimate success of the organization depends upon the cooperation given.

LEON T. COOKE
President.

Massachusetts Institutional
Laundrymen's Association.

Coming Meetings

Hospital Association of Nova Scotia and Prince Edward Island.
Next meeting, Sydney, N. S., July 6-7.

International Hospital Association.
Next meeting, Paris, July 6-11.

Courses in Hospital Operation.
Cornell University, July 12-24.

National Hospital Association.
Next meeting, St. Louis, Aug. 15-17.

Canadian Hospital Council.
Next meeting, Ottawa, Sept. 8-9.

National Association of Nurse Anesthetists.
Next meeting, Atlantic City, N. J., Sept. 14-16.

American College of Hospital Administrators.
Next meeting, Atlantic City, Sept. 12-17.

American Hospital Association.
Next meeting, Atlantic City, Sept. 13-18.

American Protestant Hospital Association.
Next meeting, Atlantic City, Sept. 10-12.

Children's Hospital Association.
Next meeting, Atlantic City, Sept. 13-17.

American Public Health Association and National Organization for Public Health Nursing.
Next meeting, New York City, Oct. 5-8.

Saskatchewan Hospital Association.
Next meeting, Regina, Oct. 10.

American Dietetic Association.
Next meeting, Richmond, Va., Oct. 18-22.

Ontario Hospital Association.
Next meeting, Toronto, Oct. 20-22.

American College of Surgeons.
Next meeting, Chicago, Oct. 25-29.

Association of Record Librarians of North America.
Next meeting, Chicago, Oct. 25-29.

Kansas Hospital Association.
Next meeting, Newton, Oct. 30.

Cancer Hospital for Bombay

Under the sponsorship of the Tata Foundation of Bombay a cancer research hospital is being built in Bombay to be known as the Tata Memorial Hospital. The initial unit will be fifty beds. Dr. John W. Spies is the medical director. Dr. Spies has been spending the past year studying cancer work in American and European hospitals. Charles F. Neergaard, New York, is consultant.

BOOKS ON REVIEW

MUSIC IN INSTITUTIONS. *By Willem van de Wall assisted by Clara Maria Liepmann. New York City: Russell Sage Foundation.* 1936. *Pp.* 457. $3.

"Music is a purposeful production of sounds associated with certain definite emotions or with concepts of beauty. Because it is prompted by man's desire for inner satisfaction, its appeal is strongest where it answers an immediate need." Thus Dr. van de Wall begins in this first book dealing with music as a part of welfare work. Both the theoretical and practical phases of the subject are presented simply and logically. The handbook is based upon experience and its ideas are applicable to educational and social work based on mental hygiene.

The book is divided into five parts: Function of Music in Institutional Care and Treatment; Aims and Scope of Musical Activities in Various Institutions; Organization of Institutional Musical Activities; Institutional Music Worker; Administration of Music in Welfare Institutions; and an Appendix giving a brief history of the work of the author in the Department of Welfare, Pennsylvania. This was apparently the first state to recognize the possibilities of music in state welfare work and Dr. van de Wall was added to the staff in 1923.

The book deals with qualities of individuals in institutions, the value of music as a psychologic influence, types of musical activity and their relative value, programs, qualifications for workers and the coordination of this department with other welfare activities.

In a brief foreword Dr. Samuel W. Hamilton, assistant medical director, Bloomingdale Hospital, White Plains, N. Y., says "Music educators in institutional fields are as yet not numerous, and it will probably be some years before their ranks will be filled by persons who are as able as those employed in teaching music in public schools."—BESSIE COVERT.

DIGESTION AND HEALTH. *By Walter B. Cannon, M.D. New York City: W. W. Norton and Company, Inc.* 1936. *Pp.* 160. $2.

Students of physiology and nutrition have been aided and inspired by the scientific investigations of Doctor Cannon since he demonstrated the first use of Roentgen rays "to study the phenomenon of swallowing." In the subsequent forty years, contributions to our knowledge of the activities of the digestive tract are ample justification for the dignified and pompous air of the goose in this first demonstration.

This small volume is a modified arrangement of the lectures given by Doctor Cannon at the centenary celebration of the annual Beaumont lectures in Detroit. It is an account of observations made over a period of years in the department of physiology at Harvard Medical School, and other researches, in which the x-ray "offered the opportunity for every doctor to be a William Beaumont and his patient to be an Alexis St. Martin."

The discussion includes facts of interest to everyone—ways the emotions affect the digestive processes and rational methods of overcoming or preventing these emotional effects; what has been learned of the nature of hunger and thirst, and a reply to the ever recurring question about taking fluids with meals; the relationship between digestion and health.

The simple pleasant style of writing makes this book interesting for both the professional and the nonprofessional reader.—LULU G. GRAVES.

NEW PRODUCTS • • •

Revolution in Needle Industry

What, another industrial revolution? Yes, indeed, but there'll be no sit-down strikes in the needle industry if everybody is as sensitive as we are. This particular revolution started about two years ago, say its agitators, the J. Bishop & Co. Platinum Works, Malvern, Pa. It was then that they introduced a point of radically new design. Now they are happily engaged in providing still further refinements in order to make the needle somewhat stiffer and furnish a point with cutting properties which have been carried to the absolute limit compatible with safety, safety being the quality that a needle should have above everything else. The needles are made of cold drawn seamless tubing which combines strength with toughness and are claimed to be free from oxide and loose scale and are chemically clean inside and out.

Castor Oil for Refrigerators

Refrigeration systems, it seems, get clogged up with air and undesirable gases which slow down the running of the plant and thus are periodically in need of purging. Comes, then, the Frick Company, Inc., Waynesboro, Pa., with the new Frick purger which blows out the noncondensable gases and saves, they say, as much as ten pounds of pressure.

This apparatus, like most equipment of the kind, operates on the principle that any of the refrigerant mixed with air and other undesirable gases will be condensed to a liquid by a cooling coil inside the drum and separated in this manner from the gases that are to be blown off. Unlike other types, however, the Frick purger operates at the highest possible pressure throughout the cycle with, it is claimed, a material improvement in economy. By maintaining the total pressure inside the vessel as high as possible, the air and other noncondensable gases will form a larger proportion of the total mixture. When the purge valve is opened, the gases which are blown out will contain the absolute minimum amount of the refrigerant.

Making Fever Therapy a Pleasure (?)

Nobody really expects to be particularly comfortable in a fever therapy cabinet, but it was with the humane intent of getting the patient hot but not bothered that General Electric X-Ray Corporation, 2012 Jackson Boulevard, Chicago, developed the G-E inductotherm fever cabinet. Thus, everything that their engineers have been able to devise for comfort as well as for therapeutic efficiency has gone into this important piece of equipment.

The cabinet is roomy to permit considerable movement of the body during treatment. An air conditioned system consisting of fan, heater, and water container, fillable from the outside, makes it possible to maintain a comfortable air temperature and relative humidity within the cabinet. The head end of the cabinet is sloped so that the patient is not cut off by a forbidding wall but can see what is going on around him, thus, according to the manufacturers' calculations, relieving somewhat his nervousness and apprehension.

The unit is light in weight and readily mobile. It is ready for use wherever there is electric current. It is designed for use with the G-E inductotherm. The electromagnetic induction cable is permanently affixed to the

framework which supports the mattress. The cable leads to two plugs which, in turn fit into the jacks at the back of the inductotherm. Hence the machine may be instantly connected or disconnected.

Without the Memory of Man

Absent-minded cooks—attention! If your special weakness is forgetting to turn off the gas or electricity when you are through cooking, consider the merits from your point of view of the new automatic heat manager control electric griddle which is offered by Edison General Electric Appliance Co., Inc., 5662 West Taylor Street, Chicago. It turns itself off and on. Putting the hot dogs on the griddle starts it to sizzling—taking them off turns off the current. Very neat. This new griddle has a heavy cast-iron heat storing grid, with cast-in calrod heating units. Accurate temperature control is provided by means of a degree-marked dial which may be adjusted to the exact temperature required for each food. The new griddle, says Edison G-E, cuts operating costs by automatically proportioning the electric fuel to the actual orders grilled, without human attention.

Light—as You Desire It

Just what the doctor ordered is the claim made for the new lamp, of the clamp-on variety, manufactured by Greist Manufacturing Company, New Haven, Conn. And we wouldn't be inclined to argue with 'em on the subject. Certainly it is a versatile piece of equipment.

For instance, it can be used by the patient for reading without disturbing other patients, by the doctor for examination or by the nurse to read temperatures, charts or perform other duties. In order to have one lighting unit serve these multifarious purposes, Greist Company decided it would be necessary to develop a clamp fitting any hospital bed into which the lamp could be placed and removed readily. Also a long extension cord, fitted with a recoil spring, was added to make it possible to move the lamp to any part of the bed. An isolated switch on another extension cord, heavily insulated to prevent any shock to the patient, may be pinned on the bed and manipulated by the occupant in the same manner as a call signal.

The standard finishes are plated English bronze and ivory. However, if you have other ideas, special finishes may be secured to harmonize with the furnishings in the room.

Out, Damned Spot!

Stains that are there won't be—and stains that aren't there, never will be. And that simple statement should make all you who have sadly shaken your heads over the troublesome stains on dishes and glassware, sit up and take notice of Keego, the Wyandotte medicine man whose incantations cause stains and deposits to disappear like magic, without the necessity for hand scouring. Keego is manufactured by the J. B. Ford Company, Wyandotte, Mich., specifically to put into solution both calcium and magnesium, the two chemicals whose presence in water cause most of the trouble, and yet leave the solution clear. Another problem, which its sponsors claim to have solved with this product, is the elimination of the need for insanitary hand toweling of dishes. Keego is said to rinse so completely that in most cases, there is no need for hand toweling. In addition, as if this were not enough, Keego's friends and supporters report that it can be used for all kinds of dishwashing—dish, glass and silver, and for all general culinary cleaning including coffee urns, refrigerators and pots and pans.

Paging New Literature

Catalogue—Ne Plus Ultra—We'll say it very loud and clear, we'll come and shout it in your ear—the new 250-page American Hospital Supply catalogue is a "lulu," from the esthetic as well as the practical standpoint. It's a beautiful typographical job, every one of the innumerable items in it is, as far as we can tell, illustrated as well as described.

What are some of the items? Let's see. Oxygen equipment, intravenous solution equipment, the vasocillator (an electrically driven oscillating bed), rubber sundries, syringes, needles and sutures, surgical instruments, enamelware utensils, paper goods, hospital garments, furniture, operating tables, sterilizers and—oh, well, write your own ticket. Incidentally, the tickets, detachable order blanks and cards, are right there at the back of the catalogue.

American Hospital Supply Corporation occupies space in the Merchandise Mart, Chicago, because, they say, in order to serve the field as they wish to serve it, they have to be in the world's largest building.

Tagging the Patient—When Mr. Popadopulous is brought in to the hospital after a bar room brawl, he may be in no condition to give his name intelligibly, or if he is, the admitting clerk probably won't know how to spell it.

In such cases, how is the record librarian going to identify his case history? Well, one way we have heard of is to install a Russell soundex indexing system which automatically brings together in a file, names which are pronounced alike but spelled differently. This device is only one of several indexing systems set forth in the brand new Remington Rand, Buffalo, N. Y., catalogue which arrived just a few days ago. Another is the diagnosis index to patients' histories which provides an avenue of reference through the title of a disease, condition or injury. When properly set up, say Remington Rand, it is of inestimable help as statistics are accumulated and research is carried on.

Cooling the Fevered Brow—There was a time when nurse used to be in the position of chief brow mopper to the perspiring surgeon during a lengthy and delicate operation. Standing under a powerful operating light for an hour or two is practically as good as a turkish bath, but who wants to perform an operation in a turkish bath?

To eliminate this difficulty the Scialytic Corporation of America, Philadelphia, has long been engaged in developing and perfecting a light, the beams of which are heat filtered and the result, it is claimed, is a cool, comfortable light in any size room and in any climate.

Its coolness is only one feature of the light emphasized in the new Scialytic catalogue on surgical lighting. It has also a light spot of variable size and intensity to meet every surgical requirement and capable of being adapted to the visual needs of every surgeon. For further dope on the Scialytic OA as well as several other types of lights, we suggest you write the manufacturers and ask them to bestow a copy of the catalogue on you, gratis.

Heart Interest—One of the trickier pieces of literature is the one just published by Sanborn Company of Cambridge, Mass., well known makers of electrocardiographs and metabolism apparatus. This small brochure, set up in the shape of an electrocardiograph case, contains an amusing and graphic set of "before and after" pictures which give the prospective purchaser an excellent idea of the improvements made in this important instrument. The "cardiette" is designed to have a wide appeal by reason of its portability, simplicity of construction and low cost. There are also other pieces of literature available which describe the "cardiette" in even greater detail.